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COMPARATIVE ASSESSMENT OF COMMUNITY HEALTH PROGRAMMES IN DIFFERENT COUNTRIES OF SOUTH ASIA

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ABSTRACT

Summary: *The policy for providing primary level care at the global level was initiated with the declaration of Alma-Ata in 1978. The countries who were signatories to the Alma Ata declaration have accepted the establishment of Community Health Policy as part of the Primary Health Care approach. Following this approach Community Health Workers were introduced in various developing countries to support Primary Health Care, while providing care in rural, underserved, inaccessible and remote areas.*

Application: *This paper is based on comparative assessment of Community Health Programmes in India, Bangladesh, Nepal and Pakistan. The assessment includes comparison of policies and programmes of community health and working conditions of Community Health Workers in these 4 South Asian Countries.*

Findings: *Community Health Workers provide valuable contribution towards improving access to and coverage of communities for basic health facilities. Community Health Workers contribution leads to improved health outcomes, however the services provided by them have quality issues in some of the countries.*

Keywords: *Comparative Assessment of Working Condition of Community Health Workers under Community Health Programmes in South Asian Countries.*

ABBREVIATIONS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker

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CHW	Community Health Worker
DDK	Disposable Delivery Kits
FGD	Focus Group Discussion
HEP	Health Extension Programme
HEW	Health Extension Worker
IFA	Iron Folic Acid
ITN	Insecticide Treated Net
LBW	Low Birth Weight
LHW	Lady Health Worker
MDG	Millennium Development Goal
FCHV	Female Community Health Volunteer
NGO	Non-Governmental Organization
NHM	National Health Mission
ORS	Oral Rehydration Solution
PHC	Primary Health Center
PNC	Post Natal Care
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNFPA	United Nations Population Fund
WHO	World Health Organization

INTRODUCTION

Community health worker (CHW) in different South Asian countries

In 1978s the declaration of Alma-Ata provided the policy of providing primary level care at the global level. All the countries who have signed the declaration of Alma Ata, have considered the establishment of programs for providing Primary Health Care supported by CHWs. Many developing countries started training CHWs in 1980s at PHC level at a mass level. CHWs known were identified as a workforce of "Human resource for Health" and given different names. Since its inception in 1980s CHWs are still providing services at PHC level in the remote and inaccessible areas of the world:

- 1800's: Feldhsers, trained persons from community were introduced in Russia, to assist Physician's and they were authorized to provide primary health care services.
- 1920's: Barefoot Doctors, were people identified from the community and provided three months of formal training in China. Their duties include health, environmental sanitation, education and immunization.
- In the year 2000 when Millennium Development Goals were developed, the role of CHWs became very important in order to achieve MDG 4 & 5 on Child Health and Maternal Health.

The CHWs are groomed under community based healthcare programmes and strengthened by the primary health care approach. The concept and practices of CHWs have varied immensely across different countries, accustomed by their objectives and economic capacities. There are eight important factors that impact the overall performance of CHWs

- Gender equality
- Criteria use for the identification and selection of the CHWs
- Training provided to CHWs
- Profile of work and future career prospects
- Incentives paid to CHWs
- Supportive supervision and feedback provided to CHWs
- Performance monitoring mechanisms in place
- Support received from the community

Who is a Community Health Worker?

A worker trained on health services, conducting tasks related to health care service delivery. A CHW may or may not have a formal or paraprofessional degree or certificate at any level of education. CHWs may also include health workers who have received some kind of training outside nursing or midwifery curricula but the training curricula is standardized and endorsed by the national Government. This category may include health workers with different roles, responsibilities and skills and also those health workers who are providing essential health services in a public health facility.

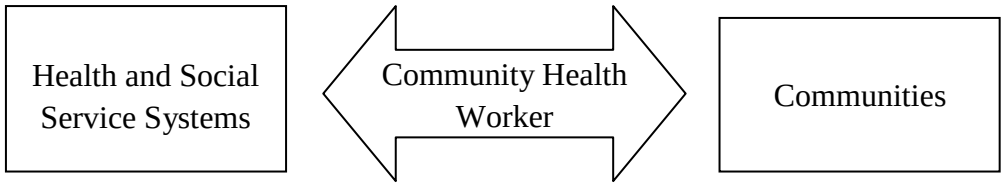
The prime objective of placing CHWs in the community is to bridge the gap between the communities and the public health service delivery systems. The core mandates of CHW are generating awareness and mobilizing community on public health services, including actions on convergent areas such as sanitation facilities, safe drinking water and hygiene. CHWs follow the principles of activism, voluntarism and they are locally recruited

from the community. The have three key roles of; supporting health care services at community level; providing counselling to mothers and families through interpersonal communication; and facilitating behavior change through social mobilization. CHWs target population or beneficiaries who are marginalized or underserved communities in the remote, hard to reach and rural areas.

Ideally these CHWs should belong to the community where they work, should be selected by the community members, should be answerable to the communities for their activities and should be supported by the health system but may or may not necessarily be a part of the formal health system, and provided short term training courses.

<table>
<tr><th colspan="3">Tasks of Community Health Worker</th></tr>
<tr><td rowspan="2">Assist in navigating the health and human services</td><td>Build individual and community capacity</td><td rowspan="2">Advocate for individual and community needs</td></tr>
<tr><td>Community Health Worker</td></tr>
<tr><td colspan="2">Promote wellness by providing health information</td><td>Provide direct health services</td></tr>
</table>

Bridging Gap Between Health System and Communities



Alternative titles for CHWs in different countries

Country	Economies as per World Bank (July 2016)	Name for Community Health Worker
Netherlands	High income	Midwives (Verloskundige)
USA	High income	Community Volunteer and Community Health advocates
England	High income	Post-natal support worker
Brazil	Upper middle income	Community Health Agents
Iran	Upper middle income	Behvarz
China	Upper middle income	Bare foot Doctors
South Africa	Upper middle income	Lady Health Worker
Bangladesh	Lower middle income	Shasthyo Sebika
India	Lower middle income	Accredited Social Health Activist
Egypt	Lower middle income	Raebat
Kenya	Lower middle income	Village Health Helper
Philippines	Lower middle income	Barangay health worker
Indonesia	Lower middle income	Kedar
Pakistan	Lower middle income	Lady health worker
Honduras	Lower middle income	Promotoras
Swaziland	Lower middle income	Rural Health motivator
Guatemala	Lower middle income	Colaborador voluntario
Nicaragua	Lower middle income	Brigadista
Ethiopia	Low income	Health extension workers
Nepal	Low income	Female community health volunteer
Mozambique	Low income	Activista
Haiti	Low income	Animatrice
Mali	Low income	Village drug-kit manager

LITERATURE REVIEW

Introduction about Community Health Workers

"Collective Empowerment: Comparative Study of Community Work in Mumbai and Stockholm." (Sjöberg, Stefan, Komalsingh Rambaree, and Bipin Jojo. 2014). This research discovered how empowerment is conducted by CHWs. The research included 13 respondents from community based organisations in two locations. In Mumbai it covered the case of extreme poverty from informal sector, whereas in Stockholm the study covered social work in public welfare model. The paper documented the contribution towards creating a welfare model in Stockholm, Sweden and Mumbai, India by helping people to articulate their voices for the development of marginalized communities. **"How Effective Are Community Health Workers?" (Perry, Henry, and Senior Associate. 2012).** This article assessed the effectiveness of Community Health Workers, which are most capable health resource since their effectiveness has been demonstrated. They can be trained in short period of time, and their cost effectiveness is significantly better than the cost effectiveness of similar services provided by other health staff based at facilities. They are also living among those people who are need of health services. In most of the low income countries, CHWs are still seen as second class service providers with second class care. The biggest gap in the knowledge about CHWs is lack of evidence on the effectiveness of Community Health programs and the factors that works as enablers. **"The global pendulum swing towards community health workers in low- and middle-income countries: a scoping review of trends, geographical distribution and programmatic orientations", 2005 to 2014.** Based on the review of publications on Community Health Workers between the period of 2005 to 2014, specific roles within the programme areas were identified. Based on the review six hundred seventy-eight publications from 46 countries on CHWs were inventoried over the 10-year period**.** The growth in literature on CHWs provided an empirical evidence of ever-increasing expectations for addressing health burdens through community-based action. **"Model of a Community Health Worker", CAN Action Learning Group on Community Development and Health 2009.** CAN Action Learning Group has defined the model on Community Development, which says Community Health Workers are based in the community and training & development are central roles of CHW. Continuous training and supportive supervision are imperative in the development of the roles. The skills that are required for community development are found in the community once there is an assurance of providing the required support and training. The employment provided to CHWs needs to be secured, they need to be properly remunerated and they should work in a team. This employment is essential in terms of the status that is attaching to the roles of gender equality, since most of the CHWs are women.

Functions and Achievements of CHW programmes

A Typology of Revenue Models for Community Health Worker Programs, International Journal for Service Learning in Engineering. This research paper has elucidated, Community Health Workers has presence in almost every developing country and have proven that they are instrumental in improving the health of the marginalized communities in their country. CHWs in most countries are volunteers depending on programs with marginal Government support and irregular external funding. Article suggests better quality of supervision of community health programmes, better monitoring and quality assurance of services through supportive supervision of CHWs will be effective and provide enhanced results. **Supervising community health workers in low-income countries a review of impact and implementation issues, Zelee Hill, Mari Dumbaugh, Lorna Benton, Karin Kallander. Daniel Strachan, Augustinus ten Asbroek, James Tibenderana, Betty Kirkwood and Sylvia Meek.** One more article has been written based on the assessment of 22 papers selected from low and middle income group countries which assessed the supervision and diversity of community health care providers. **Community Health Workers in Low, Middle and High-Income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness Henry B. Perry, Rose Zulliger and Michael M. Rogers.** The assessment has shown in low income group countries, Community Health Workers contribute towards different health areas such as under nutrition, Maternal Health and Child Health, Family Planning Services, HIV/AIDS, Malaria and Tuberculosis. In middle and high income countries CHWs also seems to be effective in improving health. However, CHWs are considered as temporary solutions and treated as second class citizens. Increased evidences have confirmed that CHWs are becoming fundamentals of population based programs and support health outcomes in high income countries as well. CHWs require active involvement of communities, full support of health systems in terms of technical interventions of training, supervision and logistical support in order to achieve their full potential.

One of the research on "**Community Health Workers in Low-, Middle-, and High-Income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness", Perry, H., Zulliger, R., Scott, K., Javadi, D., & Gergen, J., 2013,** concluded, the high income countries and upper middle income countries, female CHWs are better paid compared to their counterparts in lower middle income countries and low income countries.

Another paper **"Perspectives in Public Health Community Health Worker Programs in India: a rights-based review" (Bhatia, Kavita 2014)**, analyzed the perspectives of CHW in India. The analysis illustrated that CHWs in three consecutive CHW programs have regularly demanded improvements in service conditions and

increase payment. Notwithstanding the development of stakeholder outlooks towards rights of CHWs, service reforms are quite sluggish. Performance based incentives do not provide financial security for CHWs. In most of the countries, CHWs, being women have never been incorporated in the salaried team of health service providers. Findings suggest that lower middle income and low income group countries, CHWs are mandated to manually fill several recording formats for management information system and distribution of drugs and contraceptives which involves most of their working time, which leaves little time for the CHWs to perform their primary duties of community mobilization and counselling of mothers.

In one research paper published in **Journal of Social Work, "Social Work in Health Care: What Have We Achieved by" (Gail Auslander, 2001)** it has been observed that CHW programmes accomplished achievements in one country whereas in another country it was an issues. Social workers in health care in many countries are undergoing similar developments. Workers in some parts of the world are experiencing what other countries have experienced years ago. The scaling up and maintaining CHW programmes are apprehensive with multitude challenges such as poor planning, no coordination, uneven disease specific trainings, weak linkages with the health systems, poor coordination between stakeholder, poor supportive supervision, and under recognition of CHWs' contribution in the health services and systems. CHWs needs better integration in the national health systems through employment, supervision, incentive payment, career development for achieving better results. While achieving universal health coverage, much can be accomplished by enhancing the skills of CHWs' and support them as esteemed providers of health service delivery system. This was highlighted in the research paper on **"Community health workers for universal health-care coverage: from fragmentation to synergy", Kate Tulenko,a Sigrun Møgedal,b Muhammad Mahmood Afzal,c Diana Frymus,d Adetokunbo Oshin,e Muhammad Pate,e Estelle Quain,d Arletty Pinel,f Shona Wyndg & Sanjay Zodpeyh, Bull World Health Organ 2013**

Cost Effectiveness of CHW programmes

The Effectiveness of a Community Health Worker Outreach Program On Healthcare Utilization of West Baltimore City Medicaid Patients with Diabetes, With Or Without Hypertension, Donald O. Fedder, DrPH, MPH; Ruyu J. Chang, MD, PhD; Sheila Curry, MS; Gloria Nichols, BSP, PhD. This paper on the cost effectiveness of CHW has highlighted the CHW program resulted in an average savings of $2,245 per patient per year, with a total savings of $262,080 for 117 patients, with improved quality of life (QOL) indicating cost effectiveness. Visits to emergency room declined by 40%; ER admissions to hospitals declined by 33%, and the total hospital admissions, whereas mediclaim reimbursements have also declined by 27%. Some more papers

such as **Community Health Workers: Getting the Job Done in Healthcare Delivery**, has illustrated, how Community health workers have become progressively integrated in the healthcare teams since a growing body of evidence have proven their impact. The Rural Health Network program with CHWs in Arkansas resulted in a 3:1 return on investment. New Mexico have used CHWs to provide support services to high resource consuming Medicaid members. Results have indicated a significant reduction in emergency department visits and inpatient admissions among participants, with a total savings of more than USD 2 million post-interventions. 14 studies in the ICER report were also evaluated to determine the economic impact of CHW projects. Out of these, the majority of the studies have revealed CHW interventions have resulted in net cost savings.

A longitudinal repeated measures was used to evaluate the financial impact of CHWs on health care systems and policies. The study reviewed the service utilization, charges and reimbursements for 590 underserved men, analyzed for 9 months before and after interaction with a CHW. The study concluded the program costs were $6,229 per month and the ROI was 2.28:1.00, a savings of $95,941 annually. These data provided evidence of economic contributions that CHWs make to a public safety net system and inform policy making regarding program sustainability. **Measuring Return on Investment of Outreach by Community Health Workers, Elizabeth M. Whitley, Rachel M. Everhart, MS, Richard A. Wright, MD, MPH Journal of Health Care for the Poor and Underserved 17 (2006): 6–15**

One research article on "**How do we determine whether community health workers are cost-effective? Some core methodological issues. Journal of Community Health", June 2005**, illustrated health programs supported through primary healthcare approach with the help of community health workers, which are expected to improve the cost effectiveness of health care systems by reaching huge numbers of deprived populations with high impact services at a lower cost. There is a dearth of data on the cost effectiveness of CHW programs to indorse these findings, since conventional methods does not capture the established settings of CHW programs.

Research Gap based on Literature Review

Based on the literature review of 15 Articles and Journals it was observed a specific comparative research aiming South Asian Countries was required to understand the conditions of Female CHWs in the region. Therefore, this research paper was written based on an assessment of CHWs in different South Asian countries, through comprehensive review of literature, journals and articles available in these countries.

OBJECTIVE

The objective of this research paper is to compare the working conditions of CHWs under community health programmes in four countries of Bangladesh, India, Nepal and Pakistan. In all these 4 countries only females are identified and trained for working as a CHW at the community level. The comparative assessment includes strategy of community health programme, origin of CHWs, their selection, training and their functions / roles & responsibilities.

METHODOLOGY

This paper has been written based on the secondary data analysis of research and evaluations conducted in different South Asian countries. The key indicators that have been evaluated under the assessment have been Education required for the selection of CHW, training provided to CHW, Work Profile & Workload of CHW and remuneration / incentive / recognition provided to CHW in return of her services. In this study various research studies from different countries have been selected for comparative assessment of CHWs.

Selection of Countries for Comparing Community Health Workers

Out of 8 Countries which comes under South Asia region, only 4 countries of India, Bangladesh, Nepal and Pakistan have an established and functional Community Health Programme. Therefore, only these 4 countries were considered for this research study.

DATA ANALYSIS

This is a descriptive research study based on literature review of various research studies and articles published on CHWs in different South Asian countries.

Criteria for Comparative Assessment

In order to undertake a comparative assessment between different CHWs, 6 of the following criteria were used under this study:

i. Comparative Assessment of policies and programmes of Community Health and CHWs in different South Asian Countries.
ii. Comparative Assessment of working condition of CHWs:
    a. Training Provided to the CHWs under the Community Health Programmes

b. Work Profile including tasks performed by CHWs and their workload.

c. Remuneration or incentives paid to CHWs for the service provided by them.

iii. Success and achievements of the CHWs in their respective countries.

Comparative Assessment Policies and Programme on Community Health Worker in Four South Asian Countries

Bangladesh

Bangladesh started a community based family planning program with a cadre of family welfare assistants in 1970s. The program was supplemented by CHWs of NGO sector working in the family planning programmes in 1980s. By the end of 1997 Bangladesh was able to recruit and train more than 30,000 female CHWs providing home based health services. This program became a widely considered and one of the most successful family planning health programs amongst all the developing countries in the world. In the mid 1980s, BRAC, one of the NGOs in Bangladesh, initiated a CHW program with a cadre of women workers who were members of an NGO called BRAC. These female workers attended special training on schemes for generating income or health. These CHWs were known as Shashtya Shebikas. Over a period of time this program scaled up rapidly in a way that it represented BRAC with a cadre consisting of 80,000 CHWs that were covering over 100 million people and providing comprehensive services. The recruitment of Shasthya Shebikas are managed by BRAC Village Organizations. The educational eligibility required for the selection of Shasthya Shebika was only few years of schooling. As of date a total of 80,000 Shasthya Shebikas are currently working in Bangladesh.

Bangladesh has a Public Private Partnership (PPP) model for implementing Community Health Programmes with the help of CHW, can be described as a venture between government service and private business funded and operated through a partnership. With the help of PPP model, the country has achieved universal immunization coverage.

India

In the year 1975 Srivastava Committee Report was submitted to Ministry of Health and Family Planning, Government of India. One of the recommendation of the report was based on bridging the gap between community and the primary health center, in order to distinguish the services of health workers and the formation of a new cadre of health service providers. This report recommended a cadre of para health workers, identified and recruited in the community for providing simple health services and listed medicines for common illness and

to introduce a restorative function that will distribute the functions and responsibilities of doctors at the primary health center level. Therefore, a cadre of para health professionals or semi-professional health workers were needed within the community to provide preventive and curative health services.

Community Health Worker is known as ASHA (Accredited Social Health Activist).

Under the Community Health programme of National Health Mission (NHM) one of the key components is providing a trained female CHW / activist in every village of the country to serve the most marginalized and vulnerable rural population. ASHA workers are the residents from the same village in the age group of 25 to 45 years. The education eligibility of ASHA workers is preferably up to 10^{th} standard. Her selection process includes various community groups, self-help groups, Anganwadi institutions, block nodal officers, village health committee member and the local self-government.

Every ASHA worker approximately covers a population of 1000. ASHA workers mobilizes community and facilitate them in getting access to government health services available at public health facilities (Sub-center /Primary Health Centers) such as Ante Natal Care (ANC) Immunization, Post Natal Care (PNC), Nutrition etc. and other services being provided by the Government. She is also responsible for distributing essential provisions to all habitations like Oral Rehydration Solution (ORS), Iron Folic Acid (IFA), Zinc tablets, Co-trimoxazole tablets, Oral Pills, Condoms, etc. She counsels pregnant women on birth preparedness, significance of institutional delivery, exclusive breastfeeding till 6 months of age, complementary feeding after six months of age, age appropriate immunization, use of contraceptives and prevention of infections i.e. Reproductive Tract Infection (RTI), Sexually Transmitted Infections (STI) and care of newborn.

ASHA performs various roles for improving the health of the community such as creating awareness about services available at public health facilities. Mobilizing community towards health planning, increased access of public health services, promoting decent health practices, and providing a package of preventive & promotive care and make timely referrals.

Nepal

Nepal has three cadres of CHWs for providing health services at the community level which are Female community health volunteers (FCHVs), Village Health Workers (VHW) and Maternal child health workers (MCHW). Both VHW and MCHW are paid workers.

Female community health volunteers (FCHVs) are key cadre for providing health services in the community. FCHVs provide health promotion activities for mothers and children provide treatment and commodity distribution and lead mother groups within their communities. They are considered as the least-skilled informal health provider cadre by the MOHP. FCHVs are supervised by village health workers (VHW) / MCHWs.

Both VHWs and MCHWs are being phased out and replaced auxiliary health workers and auxiliary nurse midwives respectively. These cadres receive more training and provide more skilled services. Nepal is moving towards a more professional workforce; these workers are not considered CHWs by the Government of Nepal.

Pakistan

Adhering the signing of Alma Ata Declaration, Pakistan established a program on primary health care and family planning in the year 1993. The primary health care programme employed Lady Health Workers (LHW) as CHWs at the community level for providing health services. Pakistan has a national action plan which essentially focuses on treatment and cure while using technology for enhancing health service delivery. The plan has two behavioral change communication initiatives, through mass media and through community mobilization for generating demand for health services with the help of LHW at the community level. The community health program intended to reach urban slums and rural areas with preventive and curative primary health services and bridge gap between health service providers and patients, timely delivery of services and an increase in contraceptive use rate.

Conclusion

All the countries have a community health programme supported by CHWs identified and trained by Government, except in Bangladesh which has a Public Private Partnership (PPP) model for implementing Community Health Programmes. Under PPP model, one NGO called BRAC has been given the responsibility to identify and train CHWs periodically, through a venture between government service and private business funded and operated through a partnership. With the help of this PPP model, the country has achieved universal immunization coverage and other health outcomes. Therefore, the Bangladesh Policies and Programme model are considered to be the most successful in all the four South Asian Countries.

Comparative Assessment of Community Workers in Four South Asian Countries. Bangladesh

Shasthya Shebika caters a population of 1000. Shasthya Shebika are supervised by Shasthya Kormi and every Shasthya Shebika supervises 5 Shasthya Shebikas. Involvement of community in the tasks of Shasthya Shebika is

an important component. Shasthya Shebikas conducts advocacy at community level and support groups, discuss issues and counsel them to participate in specific problems and issues. Shasthya Shebika also involve community in the process of identification of patients for referrals. They refer patients in emergency situation, especially pregnant women, infants and also provide support in arranging transport. They also conduct follow up visit after discharge. The ownership of the Community health programme in Bangladesh is governed by the NGOs supporting this programme as well as Government.

Training

Shasthya Shebika receives 1-month orientation and induction training in BRAC Training Cell on maternal, neonatal and child health and also receives refresher training every month**.**

Work profile

The work profile of Shasthya Shebika Ante natal care, delivery care, post-natal care, Immunization, detect LBW and provide kangaroo mother care and refer for complications. Visit every alternate day 0-28 days.

Equipment and supplies

Medicines, sanitary napkins, soaps.

Working hours

Shasthya Shebika work 2.1 hrs./day

Incentives/ Remuneration

Shasthya Shebika is paid 304 takas (4 USD) per month. Additionally, they also get Social recognition and earn name and fame, monetary benefit from selling items such as medicines, sanitary napkins, soaps etc.

Professional advancement

Some Shasthya Shebika accrue experience and are sometimes used as trainers of other Shasthya Shebikas. These Shasthya Shebika has no formal retirement plan and they can work till any age. The documentation, Information management system and reporting mechanism managed by Shasthya Shebika is quite weak.

India

ASHA has been appointed in the community to undertake the following primary tasks as a CHW:

- Creating awareness on health related issues
- Providing information on government programmes on health
- Mobilizing community to access health services
- Counselling on maternal and child health components
- Escorting pregnant women for institutional delivery
- Holding monthly meetings in community
- Working in association with ANM and AWW
- Providing primary care for minor ailments

Training of ASHA workers

ASHA workers are continuously trained for building their capacities. ASHAs have to undergo series of trainings in order to acquire adequate knowledge and skills for performing her indicated tasks. ASHA worker receives trainings through 8 specially designed modules on different health promotive, preventive and treatment aspects. ASHA is provided with a village health register, ASHA diary and ASHA drug kit.

Work profile

ASHA's work profile includes Maternal Health, Antenatal care, accompanying mothers during institutional delivery and care during institutional delivery, Postnatal care, New born care for normal and low birth weight and high risk babies, counselling of mothers on breastfeeding & complementary feeding, counselling of mothers with young infants on Malnutrition, Immunization, Adolescent health, RTI/STI, Infectious disease such as TB, Leprosy, Malaria, counselling on Contraception and Safe Abortion.

Remuneration

ASHAs receives performance based incentives for all the tasks listed above along with referral of sick new born, escorting mother for institutional deliveries and construction of household toilets. ASHA are also provided with a drug-kit mainly having preventive drugs for distribution such as ORS, IFA, Co-trimaxole and Zinc tablets. She also receives additional incentives for distribution of these drugs during dedicated national campaigns. ASHA is the first point of contact for any health related demands at the community level for deprived and backward

sections of the population in the rural parts of India, especially women and children, as beneficiaries of public health services. ASHA is basically a health activist working in the community creating awareness on health, its social causes and mobilize community towards accessing health services. She is a promoter of good health practices and also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. ASHA also provides information to the community on other determinants of health such as nutrition, sanitation & hygienic practices, healthy living and working conditions.

Supervision

ASHA is being supervised by one ASHA facilitator and every ASHA facilitator supervises 20 ASHA workers. In Hilly areas/hard to reach areas 1 ASHA Facilitator has 8 ASHAs.

Under a rapid assessment of ASHAs in Udaipur District, Rajasthan in 2008-09 an appraisal of performance based incentive system of ASHAs in Udaipur District of Rajasthan was done. The study was typically a cross-sectional design with a mix of both in - depth interviews and FGDs. The summary of the expectations of ASHA regarding incentives were:

Expectations	**Urban**	**Rural**	**Tribal**	**Total**
Increase in honorarium	52 (86.7%)	45 (75%)	46 (76.7%)	143 (79%)
Incentive should be in time	13 (21.7%)	20 (33%)	37 (61.7%)	70 (38.9%)
Others	10 (16.7%)	6 (10%)	8 (13%)	24 (13%)

Most of the ASHA in all the 3 blocks voiced for increase in honorarium which at present is INR 500/- per month. There was also a delay in the payment of incentives to ASHAs. The delay is more in tribal block (61.7%). In India some of the researches have concluded that due to lack of motivation and adequate incentives provided to ASHA workers they are not being able to deliver in accordance with their required mandate. Ministry of Health, Government of India has included ASHA workers in many of the health programmes as the primary service delivery mechanisms, however as came out in some of the research studies ASHAs are not being able to perform due to lack of proper training provided by government, effective and continue supportive supervision, adequate incentives to keep them motivated, overburdened with too many health programmes and their documentation work and untimely payment.

Nepal

Nepal is a country with huge health needs and significant challenges to health service delivery. It is a low income country and most of the rural population live in hilly areas. Health service delivery in Nepal is challenging due to its geography. 40% of individuals in the hilly region have to travel approximately around 1 to 4 hours to reach their closest public health facility.

The FCHV Program started in 1988 and since its inception it faced many problems such as dearth of well-trained health volunteers/service providers, dearth of logistics, inadequate locally desired health services. There were also challenges of working in hilly areas with highly scattered rural population. They receive monitory incentives for certain tasks, but they are principally volunteers, however some FCHVs are demanding salaries as well.

Training

FCHVs received an initial training of 18 days with 5 days of refresher training in every 5 years.

Work profile

FCHVs promote healthy education through mobilization and they also counsel communities to attend immunization session organized by health system, detection of sickness & treat common illnesses, providing drugs for Tuberculosis, dispense Zinc tablets and ORS packets for the treatment of childhood diarrhoea, treat pneumonia with cotrimoxazole tablets. FCHVs support reproductive health care through distribution of contraceptives and misoprostol for reducing postpartum hemorrhage. FCHVs counsel families for generating demand for reproductive, maternal and child health services.

Equipment and supplies

Drugs for Tuberculosis, ORS packets, zinc tablets and cotrimoxazole tablets

Working hours

FCHVs are part time volunteers working on an average of 8 hours in a week

Incentives/ Remuneration

FCHVs were paid a monthly stipend, which was later discontinued. Currently FCHVs receive an incentive for retirement at the age of 60 years. They also receive free services from Nepal's retired servicemen health scheme,

medical insurance for husband and for their children. FCHVs are also given an identification card, for the recognition of their services of community mobilization, nonfinancial incentives such as clothing allowance.

Achievements

Nepal has made significant progress in last 20 years for improving health outcomes. The Maternal Mortality Ratio has declined from 539 deaths in 1991 to just 229 in 2009, and the total fertility rate has declined from 5.3 in 1991 to just 2.9 in 2009. The under-five mortality rate has also declined from 158 to 50 per 1,000 live births from 1991 to 2009. A number of other factors have also contributed in the improvement of health outcomes, however there are visible evidences of contributions made by FCHVs.

Pakistan

The Lady Health Worker Programme was started in Pakistan in 1994. The program employed Lady Health Workers as CHW and the program aimed at reaching rural areas and urban slums with preventive, promotive and curative services at Primary Health Care, improve interactions between patients and service providers, timely access to health services, increase contraceptive use rate.

Training

Lady Health Workers receives a training for 3 months in Primary Health Centre, one year on job training, one week training every month for one year, followed by a 15 day refresher training once a year.

Work profile

Initially the scope of services provided by LHWs, focused on MCH, however now it includes their participation in large health programmes, new-born & child care, treatment of Tuberculosis and health education on HIV and AIDS. Lady Health Worker activities are also advertised in mass media campaigns for mobilizing community acceptance of their services.

Equipment and supplies

Oral contraceptives and condoms and injectable contraceptives

Working hours

LHWs works 6 to 7 days in a week with an average of 5 hours daily.

Incentives/ Remuneration

LHWs receive a salary of approx. USD 343 per year.

Achievements

Coverage rates of various health services in Pakistan have improved in 2006, with LHW coverage of 60% to 70% in the rural areas. LHWs coverage has increased more in rural areas, but the program still has not reached upto most deprived populations.

CONCLUSION

CHW provides valuable contribution in generating awareness in the community towards health, hygiene, improves coverage of communities towards health services. Evidences have suggested that CHWs can conduct tasks to improve health outcomes in the community, with focus on child health. CHWs are trained to perform activities to implement health programmes at the community, however still do not provide services which have most significant health impact. The quality of services provided by CHWs have quality issues in two countries of India and Pakistan.

In order to get effective contribution from CHWs, they need to be appropriately selected, trained and continuously supported. CHW programmes require substantial support in terms of planning, training, supervision, management and logistics. CHW programmes neither a substitute for fragile public health system nor an economical substitute for providing easy access to health care for deprived, marginalized and rural populations. Several programmes have failed to achieve results due to impractical expectations from community health programmes, which has unreasonably destabilized the credibility of CHW concept.

CHW programmes are susceptible, unless they are decisively entrenched in communities. There are evidences which suggest that CHWs struggle to mobilize community to change child care practices which their families are following for years. Various examples of successful Community Health Programmes implemented through CHWs are Nepal through local mobilization and Bangladesh supported by non-governmental organizations and community based organizations. Many health programmes based on CHWs last through the lifetime of the mobilization efforts and weaken or fails completely whenever mobilization thrust is lost.

It is clearly evident that, there is growing awareness and need in the health sector for the increased value of contribution provided by community health programmes involving CHW for generating awareness on public

health service. However, community health programmes have some limitations such as social determinants, cultural practices followed by the families in the rural areas, ability of CHWs to mobilize community and generating awareness regarding public health services and getting the ownership from the community for scalability. It is essential to understand and discourse the prospect of CHW programmes which is one of the key challenge in institutionalizing community participation in public health service delivery.

CHWs are legitimately eligible for demanding regular service conditions and receiving basic entitlements as an employee, and facilitate their incorporation in the mainstream as fully functional member of the public health system and not as peripheral participants. The process of integration in the main health system will have to be a gradual process. There is a need to redefine the basic features of Community Health Programmes worldwide. Public Private Partnership (PPP) model for implementing Community Health Programmes with the help of CHW, Bangladesh community health programme has been effective and regarded as one of the most successful public health programs amongst all the developing countries in the world.

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