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Regional Brief

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

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Foreword

Pillars of Health and Wellbeing: Community Health Workers

Community Health Workers, many of whom are women, provide lifesaving services to millions of children in South Asia every day. They are role models in their communities, promoting vital health care and the wellbeing of women, adolescents and children.

The COVID-19 pandemic has further demonstrated the vital role they play in keeping the most marginalized and remote communities safe and healthy. For instance, during the lockdowns in Hyderabad of India, Anganwadi Workers like Shivamma stayed in touch with mothers via phone to promote breastfeeding, complementary feeding and the importance of playtime for children.

But despite their heroic efforts, Community Health Workers remain largely under-recognized, under-supported, and unappreciated. Too often, they are not efficiently used in the Primary Health Care systems. This has hampered governments' ability to address poor child health indicators in South Asia, notably:

1. Newborn deaths continue to account for 44 per cent of under-5 deaths globally, with almost 60 per cent of those deaths in South Asia.
2. Approximately 8 million children remain unimmunized, with wild polio still a concern in the region.
3. South Asia is home to more than half the world's wasted children, a key driver of high stunting in the region.
4. 55 per cent of all adolescent girls aged 15 to 19 are anaemic, which contributes to low body mass index and higher risk pregnancies and childbirth.

That is why we are pleased to present our findings regarding community health worker (CHW) policies and systems in seven countries in South Asia, as well as our recommendations for strengthening systems and policies to ensure the readiness of CHW programmes for their expanding roles and responsibilities.

Our evaluation has found that the complexity and range of functions CHWs perform vary across and within countries and programs, according to context-specific needs and opportunities. CHW functions have indeed evolved over time and the role of many CHWs has expanded considerably. While improvements have been made, in all seven countries, there is more work to be done. There is a real need to commit consistent funding for CHWs, increase the number of CHWs, more fully integrate CHWs in the primary healthcare (PHC) systems in some countries and finally, review and revise recruitment criteria, as well as invest in continued training and upskilling.

Enabling and empowering Community Health Workers can help our region accelerate progress towards the goals set by the Astana Declaration on Primary Health Care and the Sustainable Development Goals. Ongoing plans for PHC strengthening in many South Asian countries present a golden opportunity to further strengthen and integrate CHW systems, for the ultimate benefit of the most marginalized children and women.
We mustn't delay this investment further.

George Laryea-Adjei
UNICEF Regional Director of South Asia

Acronyms

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AHW	Auxiliary Health Worker
CBHC	Community Based Health Care
CBO	Community Based Organisation
CHW	Community Health Worker
CMNH	Centre for Maternal and Newborn Health
CMW	Community Midwife
CPD	Continuing Professional Development
DV	Domestic Violence
FCHV	Female Community Health Volunteer
FHW	Family Health Worker
FWA	Family Welfare Assistant
GBV	Gender Based Violence
GE	Gender Equality
GNH	Gross National Happiness
HA	Health Assistant
ICT	Integrated Care Team
INGO	International Non-Governmental Organisation
KI	Key Informant
KII	Key Informant Interview
LHW	Lady Health Worker
LHP	Lady Health Worker Program
LHS	Lady Health Worker Supervisor
LSTM	Liverpool School of Tropical Medicine
MOHFW	Ministry of Health and Family Welfare, Bangladesh
MoPH	Ministry of Public Health, Afghanistan
MPHV	Multipurpose Health Volunteers
NCDs	Non-Communicable Diseases
PHC	Primary Health Care
PHI	Public Health inspector
PHM	Public Health Midwife
PNC	Post Natal Care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
ROSA	Regional Office for South Asia
SAP	Strategic Action Plan (Maldives)
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SS	Shasthya Shebika
UHC	Universal Health Care
UNEG	United Nations Evaluation Group
VHW	Village Health Worker
WHA	World Health Assembly
WHO	World Health Organisation

Introduction

In 2018, the Astana Declaration reaffirmed primary health care (PHC) as the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being. It squarely sets PHC as the route to universal health coverage and the health-related Sustainable Development Goals.

The potential of Community Health Workers (CHW) to contribute to the attainment of universal health coverage and to building more resilient and holistic PHC systems is increasingly acknowledged. The critical role they play in delivering a range of preventive, promotive, and curative services related to reproductive, maternal, newborn, and child health, infectious diseases, non-communicable diseases, and neglected tropical diseases is well documented. However, challenges remain with regard to the support they receive as their integration into health systems is often patchy within and across countries. Other challenges include poor planning, unclear roles, inadequate education, limited career pathways, multiple competing actors with little coordination, donor-driven management and funding, tenuous linkages with and accountability to the health system, poor coordination, supervision, quality control, and support, and under-recognition of CHWs' contribution.

As countries move to align their plans to national post-Astana commitments, there is a trend toward increasing the public health responsibilities of CHWs and strengthening the delivery of integrated family and community health and PHC through teams of CHWs. The implications of these trends on PHC reforms and the evolution of its components, including CHW programs, need to be well understood and addressed in future plans, building integrated quality personal and population level primary care.

Object of the evaluation

To contribute to knowledge generation in this area, the Liverpool School of Tropical Medicine (LSTM) was commissioned by the UNICEF Regional Office for South Asia (ROSA) to conduct a formative evaluation of Community Health Worker (CHW). policies and programs.

The key objectives of the evaluation were as follows:

- to understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes
- to determine the key policy adjustments and interventions needed to address any gaps
- to assess the readiness of CHW programmes for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans

This regional evaluation covered 7 of the 8 South Asian countries that fall under the remit of UNICEF ROSA: namely, Afghanistan, Bangladesh, Bhutan, the Maldives, Nepal, Pakistan and Sri Lanka. The evaluation focused on 18 selected CHW cadres and the policies and system support that enable and guide their work at the national level only across 6 of the 7 countries. In Pakistan, due to its decentralized governance, the scope of the evaluation was expanded to include the provincial level.

The Institutional Ethics Review Committee of LSTM granted full ethical clearance for the study and the research associated with the evaluation follows the ethical principles and considerations outlined in the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation and UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (CF/PD/DRP/2015-001). In addition, the UNEG norms and standards were observed.

Methodology

The LSTM team used a mixed method approach for this evaluation, including a review of secondary data, complemented by qualitative data, collected through 129 key informant interviews (KIIs) with national level key informants (KIs) involved in CHW programs in the seven countries (See KII Topic Guides in Annexes).

Key informant interviews

Country	No. of key informant interviews	Type of KIs
Afghanistan	20	MoH policy makers and programme managers, development partners, International Non-Governmental Organisation (INGO), and representatives from UN agencies.
Bangladesh	23	Ministry of Health and Family Welfare (MOHFW) policy makers and programme managers, UN agencies, development partners, and local and international NGOs, including three gender focused KIIs
Bhutan	12	MoH policy makers and programme managers, NGOs, and representatives from UN agencies, including 4 gender focused KIIs
Maldives	21	MoH policy makers and programme managers, representatives from the Ministry of Education, Ministry of Gender, Family and Social Services, Civil Service Commission, UN agencies, local NGOs, health professional councils and training institutions, including one gender focused KII
Nepal	18	MoH policy makers and programme managers, representatives from the Ministry of Women, Children and Senior Citizens, UN agencies, development partners, training and academic institutions and local NGOs
Pakistan	10	MoH policy makers and programme managers at national and provincial level in Sindh and Punjab provinces and representatives from UN agencies
Sri Lanka	25	MoH policy makers and programme managers, representatives from UN agencies, development partners, local NGOs, health professional associations and unions, training institutions and private sector providers, including one gender focused KII
Total	129	

A data analysis plan was formulated with topics for analysis drawn from the following frameworks:

- Guideline on Health Policy and System Support to Optimize Community Health Worker Programs (WHO 2018)
- Health Systems Framework (WHO 2007)
- A Vision for Primary Health Care in the 21st Century and Primary Health Care: Transforming Vision into Action – Operational Framework (World Health Organization/UNICEF, 2018).
- Conceptual framework of gender norms and relations across the levels of individual, community and health system (Steege,et al, 2018)
- Gender Responsiveness Assessment Scale (WHO, 2011)

All KIIs were analysed and the findings and results from the analysis are presented in seven individual country reports and a gender analysis report. The findings from each of the seven countries were then synthesized. We present below some of the key issues and priority concerns with regards to CHW programmes in the South East Asia region. We present findings from the evaluation with references to literature where relevant, and also give suggestions for prioritized measures to address these.

South Asia context

South Asia is a high-priority region for many public health concerns. Bangladesh, India, and Pakistan are among the ten most populous countries in the world while Bhutan and Maldives are among those with the smallest population. Urbanization is also shaping South Asia's development trajectory with 34.4% of the population living in urban settings (World Bank, 2019). Of these, nearly 130 million South Asians currently live in informal urban settlements, but with rapid and uncontrolled urbanization this may increase to 42 percent by 2035.

Average government spending on health care (as a percentage of gross domestic product) in South Asia varies widely from 2.37% in Bangladesh to 10.61% in Maldives. The current overall spending on health (3.5% of GDP) has slightly decreased from what it was in the beginning of the Century (3.7%). The region consists of a wide variety of countries at varying stages of economic development, about half of each country's population lives below the poverty line (Verma and Kalra, 2020).

The member countries of the South Asia bear a disproportionate burden of disease, with 25% of the world's population and 30% of the global disease burden. Since the 1970s, South Asia has experienced

significant reductions in premature death and disability from communicable and nutritional diseases such as pneumonia, diarrhoeal diseases and malnutrition. Still, infectious disease, maternal health and nutritional deficiencies remain prevalent and contribute to substantial disease burdens (Verma and Kalra, 2020).

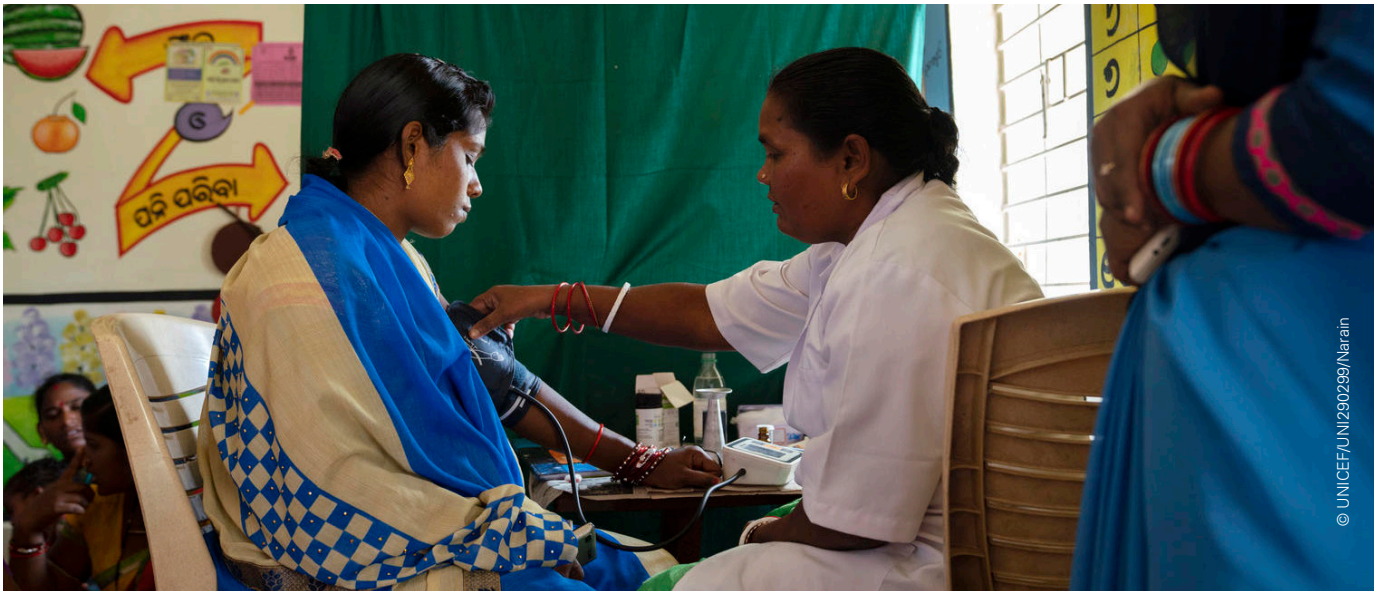
About 1 million (39%) of the world's new-born deaths occurred in the eight South Asia countries mostly attributable to infections such as pneumonia, diarrhoea, and measles. The average infant mortality rate (per 1000 live births) of South Asia was 36 (2017); a minimum of 7 in Maldives and maximum of 61 in Pakistan. Also, the region is home to more than half the world's wasted children.10 Meanwhile, NCDs have been emerging as leading causes of death as individuals are living longer and as globalization and urbanization are exposing individuals to concentrated risk factors. Deaths from NCDs rose by nearly 8 million between 1990 and 2010, and these conditions now account for two of every three deaths (34.5 million) per year worldwide. NCDs account for sizeable proportions (from one third to two thirds) of all death and disability in the region, casting increasing attention upon NCDs among public health researchers and practitioners (Verma and Kalra, 2020).

Developing countries have different demographic and geographic characteristics making it hard to realistically compare aggregate national epidemiological change. The south-Asian countries of India, Pakistan, Bangladesh represent countries that have undergone a relatively rapid epidemiological transition (in 25-35 years) from infectious and parasitic diseases and accidents to chronic and degenerative diseases. An example of the difficulty of comparing these countries is that even though Pakistan and India have experienced a great reduction in crude death rates, infant mortality did not decline at the same rate as it did in Maldives and Sri Lanka. (Verma and Kalra, 2020)

Primary Health Care reforms/ strengthening or post Astana commitments

The Astana Declaration of 2018 confirmed once again that PHC is the most inclusive, effective and efficient approach to enhancing people's physical and mental health, as well as their social well-being and to achieving universal health coverage (UHC) and the health-related Sustainable Development Goals (SDGs) (WHO, 2018; WHO/UNICEF 2018). The Declaration also stresses the importance of building sustainable people-centred PHC systems with a focus on community needs and on moving forward in terms of socio-cultural changes within communities and amongst providers.
Health policies in these countries aspire to achieve UHC for all citizens and provide accessible cost-effective quality PHC services to all citizens, reaching the "furthest behind first" and "leaving no one behind". This requires political commitment and leadership to realise the ambitious vision of PHC, and in particular the complexities associated with the three components of PHC: integrated health services, multisectoral policy and action, and empowered people and communities (WHO/ UNICEF, 2018).

Community health, as a sub-system of PHC, has a vital role to play in strengthening PHC, in expanding the provision and reach of a range of preventive, promotive and curative services and in achieving universal coverage (WHO SEARO, 2016). COVID-19 has shone a spotlight on the urgent need for UHC worldwide.



Investments in CHW compensation, supervision, continuous training, and performance management are necessary not only for rapid community response in this epidemic but also to prevent the next pandemic. Strengthening high-quality healthcare delivery systems will save lives, not just during COVID-19, but always (Ballard et al, 2020).

With an increasing burden of NCDs, it is recognised that Asian countries require "whole-of society" approaches and robust governance to provide equitable and quality care for these conditions. It is also acknowledged that to ensure appropriate, affordable and sustainable interventions, health systems in these countries need to focus on the continuum of care beyond the hospital and adopt community-based approaches. Governments in these countries need to develop policies that include everyone, "regardless of their geographical location, citizenship status, age or other characteristics" (Legido-Quigley, et al, 2018).

Continued commitment and leadership are needed to making community health a national priority within PHC and health system strengthening strategies. This needs to continue beyond policy formulation to support implementation and achieve the expected results. Respondents in many countries, highlighted the gap between health and CHW related policies and their implementation and impact on the ground. Transitions and changes in political leadership and agendas were cited as factors influencing the success of policy implementation. Respondents in Maldives, Nepal and Sri Lanka highlighted the challenges of making what are often election and political promises a reality.

A number of the countries in the study are undertaking or planning PHC strengthening. In ***Sri Lanka*** the reform and reorganisation of the PHC system is underway, guided by the 2018 Policy on Healthcare Delivery for Universal Health Coverage and implemented through the Primary Health System Strengthening Project. Reforms, expected to achieve a more effective and integrated PHC system and equitable and efficient *'family and people-centred primary health care',* will further enable the country to effectively respond to and deliver on Astana aspirations and commitments. However, respondents were concerned that the overly curative focus of the reforms may jeopardize gains made in public, preventive health and community health systems and create further disparities in investment levels.

In ***Maldives,*** the revitalisation of public health and promotive and preventive services is a national imperative, emphasized in the governments Strategic Action Plan (SAP). The 2019 high level policy dialogue on investing in integrated PHC and the creation of a continuum of care from promotive and preventive to curative and rehabilitative services made the for "promoting health and well-being" to enhance national *"resilience, employment and social outcomes"* (WHO, 2019). In particular, a case was made for greater public health investment and action in tackling the growing NCD burden, ending TB, and control and management of vector borne diseases in Maldives. However, the overall perception was that this was a positive step, respondents cautioned that the policy and PHC reform discourse needs to be commensurate with action.

Afghanistan's health policies and strategies are aimed at achieving UHC and the SDGs, and as one of the 15 Community Health Road Map countries, the health sector has prioritised community-based health care (CBHC). The MoPH in Afghanistan is aware of the need to strengthen PHC and is focused on coordinating a more coherent and integrated approach to CBHC, aimed at reducing duplication and promoting more efficient use of scarce resources. Respondents in Afghanistan acknowledged that efforts are being made to ensure that the revision and development of policies reflect Astana principles, they did however, perceive processes to be fragmented and observed that CBHC and CHW programs needed further consideration in the policies formulated.

Bhutan recognizes health as one of the nine domains of Gross National Happiness (GNH) and implements the right to health through GNH policy reforms (Meier & Chakrabarti, 2016). The 2011 National Health Policy frames the health system in accordance the human right to health, seeking to make health progressively available, accessible, acceptable, and of sufficient quality. Through its PHC approach and its disease prevention and health promotion programs. it is acknowledged that the government has achieved significant public health advancements; the first national GNH survey found the greatest expressions of citizen happiness in the health domain (Meier BM & Chakrabarti A, 2016).

The ***Nepal*** Health Sector Strategy (NHSS 2015-20) stands on four strategic principles, namely equitable access to health services, quality health services, health systems reform and multi-sectoral approaches. It calls for greater partnerships with local level institutions and community groups to empower women, promote supportive cultural practices and curb gender-based violence in the society. *In Nepal, federalism is an important opportunity for the country to strengthen the health system in Nepal and achieve UHC* (Thapa et al 2019). Respondents observed that the transition to federalism and decentralized governance and with the MoHP preparing to develop a new Health Sector Strategic plan it was an opportune time to articulate a reform agenda. It was suggested that the government should also commit to PHC strengthening by delivering a basic health care package focused on community health and health promotion, as well as on communicable and non-communicable diseases.

While ***Bangladesh*** has not articulated any specific post Astana commitments, its health policies and strategies are focused on achieving UHC and the SDGs. The optimization, harmonization and re-envisioning of CHW programmes and the role CHWs can play in achieving these goals is a key focus of ongoing health policy discourse at the highest level. These principles are articulated in the recently developed National Strategy for Community Health Workers, which affirms Bangladesh's commitment to the PHC approach, as reiterated in the Astana Declaration, and the key role envisaged for CHWs in the delivery of PHC services.

Some argue that there is a need to recognize the community health system as a definable sphere in its own right and an integral part of achieving the goal of universal health coverage (UHC). The focus should be on strengthening community health systems as opposed to on individual CHW cadres. Schneider & Lehmann (2016) define a community health system as *"the set of local actors, relationships, and processes engaged in producing, advocating for, and supporting health in communities and households outside of, but existing in relationship to, formal health structures"* and argue for a more holistic focus on this system in policy and practice. With such a view the success or failure of a CHW program or cadre would then be less attributable to the skills, scope of practice, or training of the CHW, and would focus instead on the more contextual factors, such as the social and cultural context, including community capacity to act on health issues.

CHW programs should not be perceived as an "add-on" or CHWs as lessor trained workers; *"they*

may represent a different and sometimes preferred type of health worker" (Glenton, et al, 2013). The second of the three resolutions on UHC of the 2019 World Health Assembly recognised the contribution of CHWs and urged countries and partners to allocate adequate resources to optimize CHW programs. It also emphasized the need for CHWs to be well trained, effectively supervised, and properly recognized for the work they do, as part of multi-disciplinary teams. Further, it recognised that investing in CHWs generates important employment opportunities, especially for women (WHA, 2019).

A number of these countries have demonstrated their commitment to PHC and community health and have articulated this in related policies and strategies, for example, the recently developed Bangladesh National Strategy for Community Health Workers, Afghanistan's CBHC Strategy, Nepal's Female Community Health Volunteer (FCHV) program strategy (both of which are currently being updated), the Public Health Midwife (PHM) program in Sri Lanka (as yet undocumented in explicit polices or plans), and the Lady Health Worker Program (LHWP) in Pakistan. However, all these programme suffer to a large extent from a lack of resources and system support and their full integration into the health systems is yet to be realised.

Financing

Community and household-based health services are often not a government priority and can be crowded out by other national and sub-national priorities, and health financing can be proportionately higher for curative care than for the preventive and promotive care offered through CHW programs. CHW programmes may not get sustained commitment or investment as knowledge of family planning and uptake of immunization and other MNCH services and outcomes improve. There was a sense among many respondents that health systems are skewed towards tertiary care and away from public health and primary care, with public health functions undervalued and frequently suffering from underinvestment.

However, CHW programs need adequate and sustained financing in the same way other essential programs do to achieve results (Perry et al, 2014). Investments in community health systems and CHW programs must be accompanied by corresponding investments in strengthening health facilities and equipping the PHC workforce, including CHWs, with the necessary skills and competencies to undertake essential preventive and promotive functions if they led to PHC and health systems strengthening (Nepomnyashchiy et al, 2020). Investments in community health will enable the achievement of global health objectives, as well as contribute to employment opportunities and women's empowerment.

Information in the public domain regarding the costs of CHW programs is scarce. Estimated costs for scaling up CHWs across Sub-Saharan Africa suggest an annual average cost of USD3750 to train, equip and support each salaried CHW (USD 960 annually), caring for an average population of 650 persons (McCord et al., 2013; Edward, et al, 2015). A study of community-based care in South Africa to quantify and compare costs associated with travel and service delivery demands on CHWs between urban and rural districts found that peri-urban, rural and deep-rural areas have differentneeds concerning community-based services, and such differences must be considered in resource allocation decisions (Besada et all, 2020).

Cost effective studies have outlined the cost-effectiveness and cost-saving potential associated with community health workers (CHWs) in a variety of settings (Nkonki, et al, 2017), and there is emerging consensus that CHW programs are a good investment to promote equity and access to care for poorer more remote populations (Perry, et al, 2014; Lehmann and Sanders, 2007).

The general consensus is that money spent on health, of which health-care workers are a large recurrent component, should no longer be seen as a cost, but rather an investment in prosperity and sustainable growth. Health-care workers' own unique features—strong dedication, ability to volunteer, closest ties with the community—make them extremely well positioned with regard to manifold dimensions of the SDG agenda (Shapovalova, et al. 2015).

The evidence shows that CHWs have the potential to improve access to preventive care and contribute to reduced hospitalisation and rehospitalisation rates among disadvantaged populations (Sharma et al, 2019). A 2015 literature review of CHWs in India, Pakistan, Bangladesh, and Nepal shows that these health workers reduced costs when compared to standard healthcare for both patients and providers with regards to a variety of health services provided (i.e., neonatal care, maternal education, mental health) (Vaughan et al, 2015). A recent study in Bhutan (Hauc, et al, 2020) found that *"Village Health Worker (VHW) serve as a source of cost-savings' for the country and also act as an "economic buffer for more vulnerable communities".* It was estimated that a yearly cost savings of USD1000 and over 100 averted cases for every VHW, with the majority of averted cases arising from the outpatient's department.

However, despite the strong investment case and potential for impact, current funding for PHC and community heath is inadequate. and significant additional investment is needed to build strong, integrated community health systems and programs. Respondents emphasised the need for increased financing and the diversification of financing sources and suggested that more innovative financing strategies and alternative options of financing and resource mobilization have to be explored to sustain health services overall but particularly for public health and preventive services and CHW programs.

In some countries, while CHWs were government employed and salaried, many depended on local fiscal ability of devolved health ministries and departments or local government to provide essential allowances and incentives that enabled them to carry out their activities effectively.

The right to health for all citizens, free access to medicines and supplies and the focus on specialised and curative care in some countries has diminished the resource envelope for PHC, especially the preventive and community-based health components. While increasing demand for super-specialist services and advanced health technology as seen in countries such as Bhutan and Maldives will contribute to improving quality of care; this must be balanced with affordability and rationalization of scarce resources.

In many countries, the narrow fiscal space constrains increases in domestic funding for health, but governments can use their domestic resources more effectively to meet the health-related targets and make progress towards sustainable development. Investment in reducing barriers to preventive care in PHC is necessary in order to reduce healthcare disparities, mortality, morbidity, hospitalisation rates and healthcare costs (Kieny, et al, 2017).

The evidence suggests that integrated horizontal programs rather than vertical disease-specific CHW programs could offer cost-saving opportunities and efficiency gains that could generate savings and create additional financing for identified health system improvements for CHW programs. Further, investing in strong, well-compensated, integrated CHW cadres and sustained investments in system support could begin to close the financing gap.

A "key takeaway" from the huge dataset on community health systems amassed within the Community Health Systems Catalog is that *"community health funding should align with the growing number of community health provider responsibilities".*

Multi-stakeholder and multisectoral policy and action

The Astana Declaration encourages stakeholder alignment in supporting national policies, strategies and plans and a PHC approach that focuses on multisectoral policy and action. Respondents suggested that governments should encourage and support the involvement of health sector stakeholders at all levels and establish strong platforms and mechanisms for coordination and partnerships among multiple sectors and public and private actors affecting health outcomes (e.g., nutrition, NCDs, urban health). Such partnerships would enable exploration of feasible new models for the maximization of available resources. Strengthening partnership with NGOs and Community Based Organisation (CBO) should also be strengthened to reach women in urban slums and to provide services to rural women at the household level. These countries should aim for a Health in All Policies approach, where the health sector is seen as the champion for health, keeping health on the agenda but aware of the need for joined-up work that seeks overall societal gains.

Development partners at national and global levels need to ensure funding streams and programs and technical support focus on nationally defined priorities and the support they provide contributes to more integrated approaches to PHC and community health strengthening. They have a key role in supporting the generation and dissemination of evidence on how PHC and community-based approaches contribute to UHC and the SDGs and advocating for greater PHC and public health focus.

Many of these countries have mixed health systems, with many women relying on a mix of public and private providers for their maternal care. In countries such as Bangladesh and Pakistan, some CHWs are private providers and may be the only providers available. Governments in these countries need to take the lead on engaging and working with the private sector and integrating public and private providers into a unified health system.

A shortage of data around private sector involvement in health care systems is a challenge but must be overcome to improve women's access to quality maternal health care in mixed health systems. Integrated data and information systems that include private providers will enable a better understanding of the care being given and its impact.
Sustained political commitment and robust and transparent leadership that promotes multisectoral stakeholder participation and engagement at all levels will be vital for operationalising and institutionalizing PHC reforms and strengthening plans in these countries, and for creating stronger, resilient, equitable and sustainable PHC systems.

Leadership at all levels of government, especially in decentralized health systems is required, to ensure PHC and community health systems are perceived and recognised as a key priority, even when health decision makers are not part of the leadership. These leaders can bring together multisectoral stakeholders, involve people and communities in decision making and ensure PHC and public health are adequately resourced, as highlighted in the case of Nepal and Sri Lanka. Decentralisation in Bhutan means that local governments have greater roles and responsibilities in the prioritisation and allocation of resources to respond to the needs of their districts.

However, health is only one among the many priorities and more advocacy is needed to create awareness of the importance of health to development and to get health back onto the agenda of decentralized governments. FCHVs in Nepal, many who now have political representation, could potentially be powerful agents of change in this regard. CHWs can enhance the role of communities in creating more responsive and flexible PHC systems that can recognize and advocate for local concerns and issues and enable a more rapid response.

Reaching the unreached

Structural and systematic barriers to access preventive care for low socioeconomic groups and certain ethnic groups include cost, poor integration of care between providers, and services and insufficient access to interpreters or bilingual workers. Reducing barriers to preventive care in PHC is necessary in order to reduce healthcare disparities, mortality, morbidity, hospitalisation rates and healthcare cost. The evidence shows that CHWs have the potential to improve access to preventive care and contribute to reduced hospitalisation and rehospitalisation rates among disadvantaged populations (Sharma et al, 2019).

CHWs, through their close connections to their communities and knowledge of patient's values and circumstances, can improve access to health services and ability to benefit from their programmes. A 2016 review found that CHW programmes can promote equity in terms of access to and utilisation of health services, and can improve uptake of referrals, essential for addressing the health needs of vulnerable and hard-to-reach populations (McCollum et al. 2016). The evidence also suggests that CHWs are well-poised to reach vulnerable populations (Woldie, et al., 2018). The importance of all the CHW cadres in this study as a first point of entry into healthcare systems across the seven country contexts reiterates the potential of CHWs in promoting more equitable access to PHC in particular.

This resonates with the Astana Declaration, which acknowledges that global gains in health outcomes have not been evenly shared across populations, particularly those that are poor and vulnerable (WHO/UNICEF, 2018). As such, service delivery through CHWs may help to overcome some of the barriers to accessing services that these populations face, and better understanding their role in terms of promoting equitable service delivery.

However, this evaluation also found that communities that are marginalized by caste, ethnicity, poverty, or gender, are often excluded in CHW programmes too (for e.g., specific caste groups in Nepal, tea estate and Tamil speaking communities in Sri Lanka). Specific efforts need to be made to address these groups as part of the design of community health programmes. This would require modifying and relaxing selection criteria to ensure selection of CHWs from these communities, special attention to training provided in local languages and adapted for low-literacy CHWs, and affirmative action in deploying CHWs to these communities.

Differentiated CHW programmes are needed to effectively address and inequities in the distribution of health benefits by income groups and by geographical location, gender and other dimensions. Programmes need to address the health needs of different population groups- working women, marginalized groups, adolescents, boys and men – in different settings, including in extremely rural and insecure and unstable areas, where there are no or few other health workers for example in Nepal, Maldives and Afghanistan, and in urban areas such as in Sri Lanka and Bangladesh.

With the demographic transition taking place in many of these countries, urban health services delivery arrangements and measures to expand coverage and improve quality, keeping in view the needs of the urban poor need consideration. Addressing the needs of urban populations, both the wealthy and the slum dwellers was highlighted as a growing need and one that required

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more innovative approaches, for example in countries like Sri Lanka, Bangladesh and Pakistan. Peri-urban, rural and deep-rural areas also have different needs concerning community-based services, and such differences must be considered in resource allocation decisions.

Strengthening community-based services and the Primary Health Care workforce

Many policies profess to the value of community-based care and have ambitions to improve community engagement and empowerment in the strengthening of PHC and achieving healthy population. Cadres that have a dual role in the provision of facility and community-based services, such as the Auxiliary Nurse Midwife (ANM) and Auxiliary Health Worker (AHW) in Nepal, and HAs and FWAs in Bangladesh could be better optimized and utilised, especially in the provision of community-based services through more robust supervision and monitoring systems. Splitting functions between the community and the facility is challenging to manage, with some evidence to suggest that this has led to the community-based aspects of the role being neglected in these countries. The upgrading of cadres that had previous been mostly community based has led to some being less present in the community and undertaking community-based activities.

The achievement of UHC depends upon a health workforce that is available, accessible, acceptable, and capable of providing quality services. The Astana Declaration identifies the health workforce as a key driver for PHC success. Adequate financing and sustained investment in the production, management and retention of CHWs and other PHC health care providers, especially for staffing hard to reach and remote areas, will be vital to achieve the expected PHC reforms, service coverage and equity goals.

Many of the system support gaps identified in this study can be addressed by effective and gender responsive health workforce policies and practices. Respondents identified that strengthened HR production, recruitment, deployment, retention and performance management policies and practices would be crucial in attracting and retaining these CHW cadres, as well as to optimise their roles and responsibilities, and enhance their motivation, performance and the quality of care they provide.

HR policies should focus not only on improving the training and production of additional PHC cades, but also on developing and supporting the productivity and performance of existing CHW cadres. As emphasised above, policies and practices that clarify roles and expectations, define work processes, ensure equitable distribution across geographical areas and skills mix,

and provide adequate and appropriate compensation and incentives, as well as enable effective supervision and feedback mechanisms, will lead to enhanced quality and performance.

Achieving the Astana PHC vision will require building stronger and integrated and multidisciplinary PHC workforces, with these CHW cadres recognized as an integral component. In addition, strengthening linkages and collaboration between facility-based staff and CHWs, between government and NGO/CBO CHWs, (e.g. BRAC CHWs and government supported CHW in Bangladesh), and between the PHC workforce and community-based cadres in other sectors, such as education, social welfare, agriculture (e.g XXX in the Maldives), to create these multidisciplinary and multisectoral teams.
Clearly defined roles and responsibilities and scopes of practice across all PHC cadres, supported by appropriate job descriptions, guidelines, and work processes will reduce duplication and mitigate any potential conflict. Achieving such clarity will also ensure respectful and collaborative relations and teamwork across the PHC workforce.

The 2019 Evaluation of the LHWP in Pakistan highlighted the need to carefully articulate the roles and performance management of the various cadres of front line staff involved in CHW programs to discourage competition and encourage collaboration. Roles, responsibilities, and caseloads for the various front line cadres should also be carefully mapped to the capabilities and capacities of each cadre to ensure that no cadre is overburdened.

An integrated approach to PHC that incorporates CHWs along with other parts of the PHC system (including related cadres of health workers and links to primary care facilities) is likely ultimately to be more effective and sustainable. When compared to the maintenance of vertical structures, integrated approaches to RMNCH, nutrition, immunisation and NCD programming are more likely enhance the provision of integrated, coherent, holistic and efficient people-centred care for individuals, families and communities (WHO/ UNICEF, 2018). Integrated models of care could also contribute to improved coverage and access of services to the underserved, unreached and marginalized groups, including women, children, adolescents, and the disabled. In Sri Lanka, private sector providers highlighted the need for greater collaboration between private providers and CHWs, especially in urban settings, particularly with health education and promotion of breastfeeding and child nutrition.

CHWs should be well linked into formal health system and the PHC health team. Facility-based health workers at PHC level should be aware of CHWs scope of practice and ensure that mechanisms are in place to integrate CHWs into the planning and implementation and monitoring and evaluation of interventions. Moreover, a lack of awareness, understanding, and respect for CHWs

working within the PHC system could negatively affect CHWs' ability to use their unique skillset and jeopardize their efforts to improve uptake of services.

Profiles of Community Health Workers in South Asia

Drawing on the 2018 WHO definition of Community Health Worker, the evaluation covered 18 different CHW cadres across the seven countries, ranging in number from 220 CHWs (CHWs in Maldives) up to 110,000 (Lady Health Workers in Pakistan). Bhutan and Afghanistan each have one active CHW cadre; the other five countries have two or more active CHWs. Bangladesh has the highest number, with 7 active CHWs in the country, all of which have an RMNCAH remit.

Many of the CHW programs in the seven countries are well established and most of the CHW cadres involved in the implementation of these programs have been functional and active for decades, with the exception of the recently introduced MPHV cadre in Bangladesh. The contribution of these CHWs is considered a significant factor in health gains and improved health outcomes in these areas across all the countries.

WHO definition of a CHW
Health workers based in communities (i.e. conducting outreach beyond primary health care facilities or based at peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours. **WHO 2018**

Some of the CHW cadres are both women and men, some are exclusively women, such as the FCHVs and AHWs in Nepal, the LHWs in Pakistan, and the PHMs in Sri Lanka. The range of CHW programs and cadres reviewed include government salaried cadres and government and NGO volunteer cadres, with varying educational levels ranging from literate, to semi- literate and illiterate. The CHWs covered in the evaluation include CHWs who are based in the community providing entirely community-based care at the household level (CHWs in Afghanistan, MPHVs in Bangladesh, FCHVs in Nepal, and VHWs in Bhutan) and those based in the lowest level health facility providing a mix of community and facility-based care (AHWs and AHMs in Nepal, FWA and HAs in Bangladesh, PHMs in Sri Lanka).

While the identified CHW programmes and cadres included in the study met the WHO definition, many did not fit the typical CHWs profile, in that 11 of the 18 CHW cadres reviewed are salaried full-time government employees. Out of the other seven cadre, four are unpaid volunteers, organized and coordinated by the government, namely the Community Health Workers (CHWs) in Afghanistan, the Multipurpose Health Volunteers (MPHV) in Bangladesh, the Village Health Workers (VHW) in Bhutan, and the FCHVs in Nepal. The three remaining cadres were employed by BRAC a local NGO in Bangladesh, of which the Shasthya Shebika was a voluntary cadre. There was some evidence to suggest that salaried government CHWs were less willing to work in community and were less accepted or needed by community. In the countries where there are volunteer CHWs (Nepal, Afghanistan, Bangladesh) there is a greater reliance on these cadres to provide community-based services.

Profiles and selected characteristics of CHW cadres included in the evaluation

Country	Type of CHW	Number	Gender	Employment Status
Afghanistan	Community Health Worker (CHW)	28,580 (2016)	Women (45% in 2017) and men pairs	Unpaid voluntary cadre
Government of Bangladesh (GOB)	Family Welfare Assistant (FWA)	19,583 (2019)	Traditionally Women	Formal government salaried cadre
	Health Assistant (HA)	15,213 (2019)	Women and Men	Formal government salaried cadre
	Community Health-Care Provider (CHCP)	12,293 (2019)	Women and Men	Project funded through CBHC Program Trust
	Multipurpose Health Volunteer (MPHV)		Prioritises women (2:1 woman: men ratio)	Mostly student volunteers, on MoH annual contracts; receive monthly performance-based incentives
Bangladesh NGO BRAC	BRAC (NGO) Shasthya Shebika (SS)	91,000 (2011)	Women	BRAC supported unpaid part time volunteer; receive performance-based incentives
	BRAC Shasthya Kormi (SK)		Women	BRAC employed paid part time CHW
	BRAC Pusti Karmi (PK)		Women	BRAC employed paid part time CHW
Bhutan	Village Health Worker (VHW)	1150 (2018)	Men & women; 884/77% men in 2018	Unpaid voluntary part-time cadre; working 40–50 hours per month
Maldives	Community Health Worker (CHW)	224	Men & women; 54% female in 2019	Formal government salaried cadre
	Family Health Worker (FHW)	241	Men & women; 83% female in 2019	Formal government salaried cadre
Nepal	Auxiliary Nurse Midwife (ANM)	8336	Women	Formal government salaried cadre
	Auxiliary Health Worker (AHW)	9558	Mostly men	Formal government salaried cadre
	Female Community Health Volunteer (FCHV)	51,240	Women	Unpaid part-time voluntary cadre; working 7 hours per week
Pakistan	Lady Health Worker (LHW)	92,849 (2018)	Women	Contractual/public sector employees
	Community Midwife (CMW)	8000	Women	Private practitioners
Sri Lanka	Public Health Midwife (PHM) (70%)	5746 (2017)	Women	Formal government salaried cadre
	Hospital Midwife	2485 (2017)	Women	Formal government salaried cadre
	Public Health Inspector (PHI)	1720 (2017)	Either men or women but almost all men	Formal government salaried cadre

Selected health system support elements

Country	Type of CHW	Education and Training	Supervision
Afghanistan	Community Health Worker (CHW)	4-6 months classroom and practical placement	Community Health Supervisor (CHS) – mostly men; Community Health Shura; Implementing NGO
Government of Bangladesh (GOB)	Family Welfare Assistant (FWA)	3 weeks on the job training	Male Family Welfare Visitor
	Health Assistant (HA)	3 weeks training	Male Assistant Health Inspector
	Community Health-Care Provider (CHCP)	12 weeks of theoretical and practical training	Sub-district hospital manager
	Multipurpose Health Volunteer (MPHV)	3 days training	CHCP male and female
Bangladesh NGO BRAC	BRAC (NGO) Shasthya Shebika (SS)	15-20 days initial training and one month supervised practical placement; one day refresher training per week	Shasthya Kormi (SK); BRAC Program Officer(PO)/staff
	BRAC Shasthya Kormi (SK)	18 days initial training and two weeks of supervised practical placement;	BRAC PO/staff
	BRAC Pusti Karmi (PK)	No information available	BRAC PO/staff
Bhutan	Village Health Worker (VHW)	14 days initial training and 7 days refresher	Health Assistant – mostly men
Maldives	Community Health Worker (CHW)	Ranging from 18 months for Advanced Certificate in PHC, to two and a half year PHC Diploma to 4 year PHC Bachelor's Degree	No direct supervisor identified; Technical supervision from central MOH officials and atoll hospital personnel
	Family Health Worker (FHW)	18 months Advanced Certificate in Family Health Work/no longer offered	No direct supervisor identified;
Nepal	Auxiliary Nurse Midwife (ANM)	18-months pre-service training in nursing and midwifery	Senior AHM, if not available, male AHW
	Auxiliary Health Worker (AHW)	15-months training	Senior AHW (mostly men)
	Female Community Health Volunteer (FCHV)	18 days of basic training; refresher training Every five years	AHW (Male) or ANM (Female)
Pakistan	Lady Health Worker (LHW)	15 months training (3 months classroom instruction, 12 months practical on-the-job training); 15 days refresher training annually	Lady Health Worker Supervisor (LHS)
	Community Midwife (CMW)	18 months (3 months classroom teaching; 12 months hospital based training; 3 months community placement)	Health Facility staff
Sri Lanka	Public Health Midwife (PHM) (70%)	18-month PHM/midwifery training program: 12 months theoretical and 6 months practical fieldwork	Female Supervising PHM - (340 in 2017) who receive 3 months additional supervisory skills training
	Hospital Midwife	18-month PHM/midwifery training program;: 12 months theoretical and 6 months practical fieldwork	Hospital Matron/Nursing Sister
	Public Health Inspector (PHI)	18 months training	Supervising PHI - men (261 in 2017)

Source: Extracted from country reports

Community Health Worker roles and responsibilities

The number, complexity, and the range of functions CHWs perform vary across and within countries and programs, according to context-specific needs and opportunities, with the majority of cadres in this study having an RMNCAH remit. It was acknowledged that CHWs functions have evolved over time and the role of many CHWs has expanded considerably from their original role in response to a number of factors. A number of drivers for CHW changing roles and responsibilities were identified.

- **Changing roles in RMNCAH:** Improvements in MCH outcomes and the increase in institutional deliveries in many of these countries has meant that CHWs now have less of a role in child birth, but most remain active in the provision of ANC, Post Natal Care (PNC), family planning and child health and nutrition services.
- **Demographic and epidemiologic transitions:** Many of the countries in the South Asia region are undergoing an epidemiological and demographic transition, and with NCDs accounting for a significant proportion (from one third to two thirds) of all death and disability in the region, these countries are increasingly focused on tackling the NCDs burden.

Health workforce changes: Like many other parts of the world, governments in the South Asia region are facing health workforce shortages and are challenged to attract and retain PHC and frontline health workers, particularly in extremely rural and remote areas, as well as in insecure and conflict-prone locations. CHW and community-based health care (CBHC) programs and the engagement of CHW cadres to work at the community and household levels are strategies used to relieve health workforce shortages and maldistribution and are perceived to be a cost-effective way to improve the population's health (Long et al, 2018). In some cases, CHW cadres that had originally been community-based cadres are now partly (FWAs and HAs in Bangladesh) or wholly (AHMs and AHWs in Nepal) facility-based to address health workers' shortages and are less involved in community-based activities or absent from the community altogether.

Optimizing roles and responsibilities

RMNCAH continues to be a priority area for governments across all seven countries. The general view among respondents was that while progress is being made in improving coverage of RMNCAH interventions, sustained commitment and investments and are required to safeguard the gains made. Extra effort was needed to reach the "last mile" and the most vulnerable people in the provision of RMNCAH and other services and to improve the quality of MNCH care to optimize the impact of health services.

Sustaining and expanding home-based services, based on local needs, particularly in places with geographic or social restrictions on seeking care from facilities will be key. Some were of the view that CHWs should maintain a sole MNCH focus and continue to expand their role and improve the quality of care in this area. Supporting women, particularly in the area of postpartum mental health issues and Sexual and Gender Based Violence (SGBV), through counselling, helping them to navigate the services available, providing referrals and post referral support, were areas identified where CHWs could have greater involvement.

The strong preference in most countries of South Asia for female health workers to support women and families on RMNCAH makes the availability for female CHWs that focus on RMNCAH a core and critical requirement to be addressed in the design of community health programmes, and specifically health workforce plans. Supportive health workforce policies should consider women's competing gendered professional and personal needs and responsibilities, the extent to which these affect their employment needs and preferences and their ability to take up CHW roles, or training opportunities to enhance their skills or retrain for new positions and to advance professionally in their careers (George et al, 2017).

Although there has been progress in controlling and eradicating **communicable diseases** in many of these countries, the overall consensus was that CHWs have a significant role to play in the prevention and control of vaccine-preventable, vector borne and communicable diseases.

With **non-communicable diseases and injuries (NCDIs)** accounting for more than a third of the burden of disease of the poorest in the world, and among those aged younger than 40 years, it is critical to ensure that the poorest families affected by NCDI are supported (Bukhman, et al, 2020). It was suggested that CHWs could better integrate NCD related education, promotive and preventive activities into RMNCAH interventions during household visits and community outreach and continue to refer clients to the PHC facility and generally support the PHC team with the provision of these. The literature suggests that with proper training, support, and supervision, CHWs can deliver services such as diabetes screenings, cardiovascular diseases case management, healthy lifestyle counseling, early detection, referral for priority chronic diseases, and medication compliance management in NCD programs. However, any such deployment of CHWs to NCD related work should include appropriate system support in the form of training, supervision, supplies, and remuneration, and should not be at the cost of their existing RMNCAH remit.

Given that a key aim of the Astana declaration is a PHC approach that empowers people and communities, the role of CHWs in promoting community engagement and participation in health was perceived to be key.

Respondents suggested that strengthening CHWs' social and behaviour change communication (SBCC) skills would enable them build rapport and trust with mothers and family member and promote appropriate care seeking and participation in health.
Along with improved knowledge and skills in health promotion and SBCC, familiarity with a range of media that can be used to ensure CHWs could reach less accessible population groups with reliable and accurate information, especially adolescents and youth, who rely heavily on the internet and social media for health information. However, any mHealth initiative should consider the social and cultural context, the attitudes and capacity of the user, the messages to be communicated and the audience for which the message are intended. (Tariq and Durrani, 2018).

Workload of Community Health Workers

As several respondents highlighted, many CHWs are now overloaded with additional responsibilities, which has not been accompanied by an increase in the supply and availability of CHWs or adequate training, supervision to ensure they can carry out these duties

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and to the standard required. There are very high expectations of the volunteer cadres, despite their working on a part time basis. Excessive workload was perceived to be a barrier to CHW effectiveness as it limited frequent interaction with the same households, and the time and space CHWs needed to establish and maintain relationships with individuals, families and communities, which compromised the overall quality of care provided.

Part time unpaid volunteers in Afghanistan and Nepal were perceived to be overworked and this was affecting the attraction of retention of these cadres. The part time nature of the work appeals to those who need time for household and other income generation activities but can be eroded with increased demands and expectations that these cadres will take on additional tasks and an expanded scope of work. The scope of these cadres needs to be better safeguarded by supervisors and program managers. In Afghanistan, respondents suggested that the MoH needed to provide greater stewardship in managing and coordinating stakeholders' expectations of CHWs roles and responsibilities. Community members and groups also need to be aware of CHW working hours and remit. In a number of countries, including Afghanistan, Pakistan and Nepal, CHWs established a health post or "health house" in their homes may create the impression that they are on duty and available to the community 24/7, which may also contribute to their work pressures.

The overall perception was that CHWs' activities and expectations should be clearly agreed, defined, and documented in a job description, a scope of practice or some type of formal agreement in the case of volunteers. This exercise could be undertaken by the relevant coordinating body or department within the ministry of health responsible for the CHW program. Government CHWs are employed and contracted under civil service rules and regulations, linked to job descriptions. Documented job descriptions for some of the volunteer CHW cadres were available in some countries, (in Afghanistan and Bhutan) but not for others in Bangladesh and Nepal. There was no evidence presented or found of formal written agreements or contracts that specified role and responsibilities, hours of work, remuneration, working conditions, and rights, especially for the volunteer cadres. There are often expectations that the role will last for a certain period of time. For example, FCHVs in Nepal are expected to work for at least 10 years, though many reportedly exceed this, while VHWs in Bhutan must be willing to commit to the role for a minimum of one year.

Respondent in some countries acknowledged that CHWs' job descriptions or scope of practice needed to be reviewed and updated. It was suggested that a first step in this review should be an assessment of the CHWs current roles and responsibilities, in terms of workload and utilization and the extent to which the health needs of all population groups are being met in different contexts. The process should include a capacity assessment to determine the knowledge, skills and competencies needed for the role, identifying gaps amongst the current stock of CHWs, and using the findings to inform the design and delivery of pre-service education and in-service training plans and curricula.

However, even with relevant job descriptions, the package of services CHWs are expected to deliver and the target population to be reached with these services needs to be realistic and achievable. Respondents emphasized that additional activities should not interfere with or undermine CHWs' ability to undertake their core RMNCH and other functions. CHWs' work at the household level with women and other family members should be safe guarded and not crowded out by other activities, enabling them to contribute to their government's Astana commitments to UHC and equitable access to all services for all individuals, irrespective of their gender.

With an expanding CHW workforce, it is suggested in the literature that CHWs could be separated into at least two teams: one for acute and preventive care, and another for chronic care, or create polyvalent cadres. There are also a growing number of models, such as integrated care teams (ICT), close to the community health facilities, such as health centres and health posts, and use of CHWs that promote a continuum of care and can optimize the integration and clustering of related services (Bukhman et al, 2020). Respondents also suggested different models for ensuring the provision of essential services and improving the coverage, reach and quality of the services delivered. These included producing different types and/or creating different grades of CHWs, with some undertaking more specialist roles in RMNCAH, communicable diseases, and NCDs, while more generalist CHWs provide a range of services, including basic services, health education and promotion, community engagement, data collection, among others.

Health system support for Community Health Worker programs and cadres

The WHO guideline recommends several measures of health system support for CHWs to function effectively. While several of these recommendations were found to be fulfilled either completely or partially in the countries in the region, there were also several areas where countries fell short of adhering to these recommendations.

Selection, education, certification

Selection

Selection criteria commonly hinged on educational attainment levels. In basically every country for which detail around selection criteria were apparent, these

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specific criteria often have to be relaxed, particularly in rural areas, to meet other criteria specifying that a CHW must be from the community they serve. This relaxation of educational requirements was not without consequence and there were often implications for data collection (which less-educated or illiterate CHWs struggled with) and the ability to carry out duties as expected (in particular, providing counselling around complex topics like danger signs, or carrying out appropriate referrals).

Many of the CHWs that met the WHO definition did not always meet the WHO selection criteria that specify that CHWs should be members of the communities they work in and should be selected by and answerable to the communities. As described earlier, the recruitment of government CHWs employees is governed by civil service rules and regulations, with no community participation in the selection and recruitment processes. Some respondents noted that nepotism and favoritism were sometimes factors in the selection of CHWs. This may endanger the aim of the CHW programme in achieving inclusive and equitable health, as instead of addressing the needs of the poor and underserved groups, more privileged community members may benefit from the CHW's services.

Education and training

Once selected, the **pre-service or "initial" training** for the CHWs reviewed ranged from 3 days for MPHVs in Bangladesh to four years for degree level CHWs in Maldives. CHWs in Maldives, Nepal, Pakistan and Sri Lanka, all of whom are government employed CHWs, received training for up to 18 months or longer in accredited government training institutions and most were registered with the relevant professional council. The initial training provided for voluntary CHW cadres and for some government CHW cadres, such as HAs and CHCPs in Bangladesh, was of a shorter duration and in many cases was not accredited or certified.

In many of these countries, the delivery of training and provision of learning materials was in the local language, which enabled more flexible selection criteria and improved the participation of those with low literacy levels and also optimized the trainees' acquisition of expertise and skills. This was more appropriate with volunteer cadres, who were mostly community based.

The WHO Guideline recommends that CHW education and training is competence based. While most training programs consisted of theoretical and didactic learning,

as well as supervised practical learning, the modalities and quality of the practical training to allow trainees apply acquired knowledge and skills, however, were questionable, with respondents identifying a need to strengthen these in many of these countries.

In some cases, the curricula used to train CHWs had not been updated in several years which creates a mismatch between education strategies and population needs. Curricula should be regularly reviewed and revised to include and reflect new and relevant information, technological advances, changing disease burden, and evolving CHW roles and responsibilities, as well as to ensure the education and training provided addresses the health priorities of the community and the country.

Curricula revision and development could also provide opportunities for a broader focus to build CHWs skills and competencies to provide people centred and holistic care, to be change agents in the communities they serve, and to support people to challenge or address their economic, environmental, political and social determinants of health and contributes to protecting vulnerable populations, as well as promote more interprofessional education approaches (WHO 2018). Respondents in the Maldives felt that linkages between the training institutions producing CHWs and the MoH need to be strengthened to ensure supply matched demand and the content of training curricula was relevant and appropriate to meet the population's health needs.

In many cases, the skills and competencies of trainers and faculty need improvement. Academic faculty in some countries were not receiving the necessary continuous professional development or did not have the appropriate skills or experience to deliver the training. The use of training needs assessment and training evaluation to design professional development courses for trainers or inform curricula revision and/or development were little reported.

As the WHO Guideline suggests training should be in or near the community wherever possible. This was particularly important to attract sufficient female trainees. In some countries there were cultural constraints on women's mobility, such as in Afghanistan, and in others, women household and family responsibilities made it difficult for them to participate in training of an extended duration away from the home. In many cases the training of CHWs, especially volunteer CHWs happened in isolation, and except for the trainers, there was no involvement of other health care providers in the training. Facilitating interprofessional training approaches and courses should be considered where relevant and feasible to build collaborative and cohesive relations and teamwork across the PHC workforce and a better understanding of the different roles and responsibilities of the cadres responsible for the provision of care at this level.

While the WHO guideline was largely silent on in -service training, such training along with mentoring and continuous professional development (CPD) are as important as initial training in enabling CHWs to acquire and maintain knowledge, skills and attitudes required to meet the changing health needs and expectations of the population, as well as the achievement of positive CHW program outcomes (Scott, et al, 2018). A number of studies have found that if regular refresher training is not available, acquired skills and knowledge are quickly lost and that good continuing training may be more important than who is selected (Lehmann and Sanders, 2007).

However, there were challenges with the quality and delivery of in-service and refresher training in all the countries reviewed. Many of the CHWs are deployed

to remote areas after receiving the initial training and given the brief duration of the initial training, continuous training, coaching, mentoring and supervision to assure quality of care and safe practice will be vital. However, it is often difficult and costly to reach them with face-to-face learning; greater use of e-learning and telemedicine to improve access to specialist expertise and to reinforce and build on initial learning should be considered. Relatively high CHW turnover and the inability to keep up with the training of replacement CHWs was a persistent challenge that often stemmed from poor budgetary allocation, inadequate numbers of trainers, and a lack of training supplies.

Some CHWs were undertaking tasks for which they have not been trained. In some cases, challenges around attracting new CHWs is resulting in a significant number of CHWs who have now been in the workforce for a long time without receiving in-service or refresher training to update their skills and knowledge. In-service training was often the remit of facility-based staff but it was unclear what training and competencies these health workers had to provide this effectively.

Global Competency Framework for UHC under development by WHO has been designed with a population needs focus and aims to align education strategies with national context, health systems and population health needs. This framework will be useful for guiding the design and delivery of curricula for CHWs and other PHC health care providers.

Management and supervision

Supervision

When performed well, and when used to support performance improvement and professional development, 'supportive supervision' can have a positive effect on health worker's performance, job satisfaction and motivation and the quality of services they provide, and increase retention, when compared with traditional or no supervision. (Rowe et al, 2005; WHO, 2017; Kok et al, 2018; Scott, et al, 2018). Supervision is an opportunity for CHWs to have their skills and knowledge assessed by their supervisors to identify and close any gaps, which encourages CHWs to work better (Najafizada, 2014). Weak support, supervision and management have been identified as factors in job dissatisfaction in many countries (Henderson and Tulloch, 2008).

While respondents agreed that supportive supervision as an important element to improving CHW performance and motivation, they identified challenges to the provision of quality of supervision. Many countries lacked a critical mass of supervisors and even where countries had the required supervisor-CHW ratios, many lacked supervisory skills and competencies, or could not carry out supervision visits or spent too little time with the CHW because they were overburdened and overcommitted. In addition, the unavailability of resources for transport and geographical constraints were barriers to the provision of quality and consistent supportive supervision. There was little evidence of the existence of standardized supervision processes and mechanisms and the use of supervision tools, with data analyzed and feedback provided to improve quality and few reports of supervision involving clients and community.

In most countries' supervision lacked the "supportive" and "performance improvement' aspects, and there were few reports of mentoring or coaching observation, or community and facility community feedback. Supervisors attitudes and communication were a cause of concern, and supervision often focused on inspection and criticism, providing little in the way of constructive or valuable feedback for performance improvement. Failure to feedback or act on the outcomes of group or individual supervision was highlighted across many of the countries.

There was a perception in some countries that supervision was not valued or viewed as a priority by the health system. Respondents who had a supervisory role expressed frustrations at the lack of technical capacity and resources to enable them carry out regular and effective supervision.

Sri Lanka was one of the few countries that seemed to have a structured and established system of supportive supervision at multiple levels of the health system, trained supervisors. and standardized supervision and performance evaluation guidelines. However, Sri Lanka also suffers from too few supervisors, with respondents reporting that most supervision was through group reviews in the health facility. PHMs would like to have more one-on-one contact with the Supervising PHM and receive support and mentoring in their health posts in the community.

In Sri Lanka, the best performing PHMs are recognized and rewarded, while in Afghanistan there is an annual CHW day observed, which were perceived to improve motivation.

Supportive supervision is critical in decentralized systems where district supervisors are often the only human contact between health workers in remote villages and the rest of the formal health system, as seen in many of the countries in this study, such as remote islands in the Maldives and remote mountainous areas of Nepal. Continuous supervision will not only reduce the sense of isolation that some of these CHW may experience but will also help to sustain their interest and motivation in their assigned tasks In the Maldives, remote supervision through phone calls and other social media platforms is used to reach CHWs and other health care workers in the more remote islands, however these methods were mainly reserved to discuss or review basic topics and for status updates.

Adequate investment and attention should be dedicated to building the capacity of supervisors and ensuring they have the necessary tools and resources, and the time necessary to provide 'supportive' supervision. Supervision and mentoring should be carried out in a systematic manner by competent supervisors, irrespective of whether they are dedicated supervisors or healthcare workers. Supervisors should understand the CHWs' role, have an acceptable level of proficiency for the areas of practice that they are supervising and good communication and interpersonal skills. Supervision that focuses on "supportive" approaches, quality assurance and problem-solving will be most effective at improving CHW performance as opposed to more bureaucratic and fault-finding approaches.

Gender should be considered in selecting supervisors, for example, having mostly male supervisors for mostly female CHW may be culturally inappropriate and reinforce gender barriers and limit the acceptability and effectiveness of supervision. The quality and results of the supervision should also be regularly assessed. In Afghanistan, a majority of male supervisors together with strict gender segregation practices, results in many female CHWs receiving very limited supervision and support. There was also a lack of clarity in some countries (for example in Bangladesh and Maldives) about who is responsible for the supervision of CHW cades.

Improving the quality of supervision and the modalities of providing supportive supervision need to be prioritised in these countries, especially the coaching and mentoring of CHWs, the observation of practice, the use of data for performance improvement and community feedback. Supervision that involves oversight from a health worker at a peripheral facility is costly and often difficult to implement. Alternative approaches such as group supervision, peer supervision and community supervision would help to distribute the supervision tasks and improve the quality of supportive supervision to CHWs, although the feasibility and effectiveness of these approaches will depend on the context.

Remuneration of Community Health Workers

Even if a salary is not provided, WHO recommends paying CHWs commensurate with the demands of the job. While some CHW cadres in the region are full time employees receiving a fixed salary (PHM and PHI in Sri Lanka, ANM and AHW in Nepal, FWA and HA in Bangladesh, CHW in Maldives), some are completely voluntary (VHW in Bhutan, CHW in Afghanistan). There are some cadres like the MPHV in Bangladesh who receive performance-based incentives, while non-monetary incentives are provided to VHWs in Bhutan and FCHVs in Nepal. Many CHWs receive allowances for transport and communication and in some case towards the establishment of a health post or clinic.

Lack of remuneration was found to be a source of discontent and reason for attrition of CHWs in several countries in the region. In many cases, allowances were perceived to be inadequate and it was suggested that sufficient allowances should be provided to cover costs and enable them to move around to carry out their activities effectively, including to conduct supportive supervision and communicate with clients. Disparity between the remuneration of public health and CHW cadres and that of the curative health professions in some countries was also a source of dissatisfaction, including in Maldives, and Sri Lanka. Reducing such disparities could contribute to improved CHW motivation and reduce and prevent divisiveness and resentment, which could have an adverse effect on team and collaborative work across the PHC team, and ultimately the provision of delivery of integrated PHC services.

Most KIs found the non-payment of volunteers unacceptable, especially as volunteer CHWs tended to be individuals in the more remote areas where there were limited sources of income. They felt was unfair to assume poor men and women should put aside time to work voluntarily, and who, by taking up a CHW position, then had less time to spend on income generating activities and household duties. Voluntary CHWs are also more likely to either leave their volunteer work if other opportunities arise or dedicate less time to their role (Najafizada et al, 2014). Bhutan has a high level of attrition amongst the VHW due in part to the voluntary nature of the role and the lack of incentive.

Expecting CHWs, a majority of whom are women, to work at very low pay or on voluntary basis also reinforces existing gender norms. Literature demonstrates that women are paid far less than their male counterparts and undertake a significant portion of unpaid work (Sen and Ostlin, 2008). Yet, by paying female CHWs a rate that is not deemed 'acceptable' for men, CHW programmes are further perpetuating the inequalities that exist and placing women at further risk of male power.

While some female CHWs feel empowered by their role and by the social status they gain within their communities, for example many FCHVs in Nepal do not want to leave the role when they reach the age of retirement. This is echoed in the literature which suggests that CHWs who enjoy social prestige are much more likely to remain in their role (Kok et al, 2014). Other studies have shown that remunerating previously volunteer CHWs may affect their relationship with the community, who and my question their motivation and credibility (Zulu et al, 2014), a view that was also expressed by some respondents in Nepal.

However, to assume that women can find time for volunteer work is deeply problematic (Ved et al, 2019). Labelling work as 'voluntary' also reinforces the perception that women have domestic duties they need to work around. Women's unpaid caring work needs to be formally recognized and valued to break the harmful gender norms that assume women are easier and cheaper to hire and that women's labour is more pliant.

The WHO Guideline suggests not paying CHWs exclusively or predominantly according to performance-based incentives. Monetary incentives tied or untied to performance, often bring a host of problems because the money may not be enough, may not be paid regularly, or may stop altogether, as was seen in different examples from the region. Monetary incentives may also cause problems among those CHW cadres who are paid and those who are not paid. The use of incentives to improve performance typically requires good regulatory frameworks, management capacity and robust information systems to measure performance outcomes against quantified objectives (Henderson and Tulloch, 2008).

Where the health sector is severely under-resourced it is difficult to hold people accountable for how they do their jobs. Health workers must be well informed about the performance objectives, the criteria for meeting those objectives, the use of monitoring tools/systems, and the resulting incentives or disincentives that are based on their performance. In some settings in the region, it may be more practical and culturally acceptable to offer incentives to teams rather than individuals.

Career advancement

A lack of career advancement opportunities is a key demotivator in CHW programmes (Kok et al, 2014). Career mobility for these cadres for most of these CHW cadres was almost exclusively limited to becoming a supervisor of the CHW cadre, with these CHW supervisory positions more likely to be occupied by men. Limited career progression opportunities were perceived to be a key cause of attrition among these CHW cadres.

Integration with health system

Recognizing community-based health care as a sub-system of PHC and the overall health system will help to strengthen the collaboration between CHWs and the facility-based formal health workforce. Studies have shown that CHW's links or 'embedment' in the health system and the attitudes of other health staff factors can influence CHW performance and motivation and increase their credibility. Further, recognition, communication and coordination between CHWs and clinical staff can lead to improved integration and quality of care (Kok et al, 2014; Zulu et al, 2014). Supportive supervision and appropriate training can also make CHWs feel that they are a part of the health system. The extent to which CHWs liaise with and relate to other health care providers was not very well reported. Beyond their designated supervisors, there appeared to be little interaction with facility-based health care providers. CHW cadres that are based in communities, rather than primary care facilities, were described as having little interaction with other healthcare providers.

Strategies and plans for specific community health cadres should not be standalone but rather the focus should be on community-based health care or health strategies that integrate community health Investment and support to strengthening the PHC workforce. Continued planning and management of the CHW workforce as an integral part of the PHC workforce team is essential and HR policies that include CHWs in workforce planning and budgeting are critical, as is the need to maintain up to date and accessible CHW registries or databases by health catchment area to track gaps in CHW coverage. For example, the VHW cadre in Bhutan are not included or reflected in national health workforce data.

Community engagement

Community engagement, education and empowerment are necessary conditions for the effective use of PHC services. Harnessing the potential of CHWs, who through their work with families and households have established trusting relationships, accumulated significant social capital and achieved the status of influential social actors and change agents, will enhance such engagement as well as improve the coverage, and reach and equity of PHC programs. However, while this is a significant aspect of the CHW role, the absence of adequate system support, along with restrictive cultural and gender norms, often limit their capacity to engage and negotiate with their communities to create "active and empowered citizens capable of claiming ownership of the health programme" (Saprii, et al, 2015).

The CHW's relationship with the community is important for the community's engagement with the health system and building confidence in facility-based services. For example, it was reported that clients in Afghanistan got quicker service and more respect from facility-based cares when they were referred by the CHW. However, more often than not community health programmes are sets of interventions driven by national programs or donor projects rather than an integrated package of services. A more integrated approach to the delivery of community health services would be more effective in engendering lasting community engagement for sustained impact. A promising example was reported in the Maldives, where UNICEF is supporting the establishment and functioning of Community Social Groups that work collaboratively to address the needs of vulnerable and marginalised individuals and their families in a holistic and people centred manner.

The literature also highlights how community support and strong social connection often enhance the mental resilience of CHW and other healthcare workers. When this community cohesion is compromised, especially during health emergencies such as COVID 19, distress and demotivation can occur amongst these cadres. Understanding these shifting community dynamics and supporting the physical safety and psychological well-being of CHWs will be vital during such emergencies (Dean, et al, 2020) .

Trusted CHWs who are from and live permanently in the community are critical for engaging and empowering people and communities, especially populations that are marginalized; enabling their voices to be heard and advocating for their representation and meaningful involvement at the community level. By providing health services that incorporate the perspectives of individuals, caregivers, families and communities as participants in and beneficiaries of health systems, CHWs and other PHC health care workers can enhance people-centred health services.

The selection of CHWs that live in the community or who are culturally and socially similar will enhance these aspects of CHW programs. In the past, the majority of CHW were from the community they served, but this is not always the case now, especially given the health workforce shortages that many of these countries are experiencing in some countries, where more government CHWs are being deployed or transferred to posts outside their home area. For example, in some areas of Sri Lanka more PHMs are from outside the community, because of a lack of local PHM graduates. Social, cultural and linguistic differences between the CHW and community member may affect the community's acceptance of these CHWs and uptake and impact of their interventions they provide, as well as the CHW empathy toward the community (Sharma, et al, 2019). CHWs must be trained in appropriate and respectful interactions with all community members and in how to respond to difficult people or situations (Lehmann and Sanders, 2007).

Community engagement and participation were often theorised and articulated in health policies and PHC reforms and strengthening plans in these countries, but how this occurs in practice was not very well articulated in the secondary data or KIIs. Most countries have community structures and local leaders that support and participate in the CHW programs in their communities. Respondents indicated that the community have a role in CHW selection, but there were often contradictory remarks, highlighting that, in practice, "community selection and oversight" really rests with community leadership and those in positions of power and influence, which tended to bias selection processes towards family members or influential people in the community. Some of these structures

also have an "oversight" role, however what this meant in practice was not well articulated. Critically, it was observed that some structures mandated to oversee the CHW program in their communities. often did not fully understand the roles and responsibilities of the CHWs.

Where this community engagement was more robust was where there were pre-existing village health committee structures, for example, the Community Health Shura in Afghanistan; the Community Groups, and Community Support Groups in Bangladesh and the Mothers' Group for Health (MGH) in Nepal. These groups would expand their role to encompass CHW selection and oversight of CHW programs and interventions.

It is important to involve communities in all aspects of the CHW programme but especially in establishing selection criteria for CHWs and in making the final selection (Lehmann and Sanders, 2007). Accountability of CHWs to the community can also facilitate action on social determinants of health by CHWs (Nandi & Schneider, 2014). Further work is needed in these countries to build transparent and equitable community networks and local health governance and to broaden their membership to include multistakeholder representation. Improved participation of women and marginalized populations is also vital to ensure such structures meet user needs and are accountable to the individuals and communities they serve.

Community mobilisation of resources was often not mentioned in the literature. In some countries, respondents described how local women's groups and committees (e.g. the Mothers' Group for Health (MGH) in Nepal and the Family Health Action Group in Afghanistan) support CHWs in the delivery of interventions or health education activities in the community, which helped to lessen their load.

Respondents and the literature highlighted the increasing politization of the CHW workforce in some countries and the negative effects this can have on the legitimacy and credibility of the CHW. For example, in Nepal, FCHWs were prominent in recent local elections, with some now holding political office. In Sri Lanka, politically affiliated unions and professional associations are prominent. In Maldives, respondents reported that the CHW's and FHW's access to households depended on their political affiliations. Cultural and religious factors may prevent certain groups discussing sensitive topics or taking up specific services offered by the CHW, highlighted in Maldives or if the CHW is the wrong gender, as in Afghanistan.

Gender

Although community health programs and CHW policies were found to be gender neutral in their design, gender was found to be a key determinant that influenced the effectiveness of CHWs in South Asia. In the conservative and patriarchal societies of South Asia, with a majority of CHWs being women in most countries, women CHWs faced gender issues at several levels – within their own families, in their communities and with their interactions with the health system. Gender norms prevalent within their families and communities affected CHWs' ability to be mobile and travel, their interactions with girls and women, and particularly men, and had implications for their workplace safety. Community leadership positions were often occupied by men, who privileged men in some countries for CHW roles, and influenced the interactions women CHWs had within their communities. Gender was also seen to intersect with caste, ethnicity, geography in different settings, affecting the services of CHWs, especially their reach of marginalized communities. CHWs themselves internalized the gender norms of the societies they belonged to and thus reflected these in their own service provision.

Health systems were also seen to perpetuate gender disparities through their policies and programmes. Selection criteria of CHWs often disadvantaged women because of specific minimum educational requirements, and the need placed on CHWs to travel, often with no mobility support. Women CHWs' limitations due to their gendered roles in childcare and lack of mobility were often cited as justifications for their being in low paid or volunteer positions and for lack of career advancement opportunities. Women's specific gendered needs in terms of training, mobility support, and workplace safety were often not considered in CHW programmes and policies. Key informants pointed to the lack of women in senior leadership positions within health authorities and that policymakers were often themselves gender blind in their approaches.

Health workforce polices should ensure that gender disparities in the remuneration, planning, recruitment, deployment, retention and motivation of these cadres and the overall PHC workforce are addressed. HR and health information systems need to be capable of generating data disaggregated by sex and other social stratifiers (e.g. age, location, ethnicity, etc.), to complement existing data on the stock and distribution of the available CHW cades. This will enable a more in-depth assessment of the extent to which gender disparities exist, which can be used to inform the design of evidence-based HR policies and practices to address these.

On the positive side, there were several examples of policies that made an effort to be gender transformative. Several countries had included training on Sexual and Gender Based Violence as part of their CHW training curriculum and included identification and support to SGBV survivors within CHW roles and responsibilities. There were efforts to involve men CHWs to influence men and boys and challenge existing gender norms. At the policy level, there were efforts to mainstream gender within all policies and within different sectors and departments. These are positive developments that need to be supported with adequate financial and other resources.

Women CHWs can also play a positive role within their communities to act as role models to young girls and women and play a gender transformative role. This was however seen to require much more support in the form of sensitization and training of the CHWs themselves in order that they unlearn and overcome their internalized gender biases, and ongoing support to them to play change agent roles for gender transformative developments in their own communities.

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Annex 1 Key informant interview guide for national level informants (Generic)

Potential informants: policy makers and national opinion leaders; officials from Ministry of Health and from other relevant community health, gender, women's' affairs line ministry officials; representatives from local government and civil service; professional association and regulatory bodies; development partners and donors/funders; representatives from international and local NGOs, private sector, and training providers.

Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders of policies and systems support for CHW programmes in the country in order to enhance the effectiveness of the health care system and strengthen health outcomes in the country.
- Ensure each participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheets, consent forms, country specific CHW map, CHW definition; definition of support system; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration; figure of WHO HS Framework; and country-specific desk review findings.

Please include the following details and participant profiles as part of the recording:

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organisation
- Number of months/years working in this position

For example: 'This is a key informant interview in the Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'.

A. National CHW programmes and cadres

1. What is your role in CHW programmes in this country?

2. Are the following key CHWs, (*name cadre(s)*) identified for (name the country), correct? (*Provide agreed study CHW definition, if required)*
    a. If not, which cadres should be omitted or added? (For those added, probe for their roles in Q3 below)

3. Which of these CHW cadres or programmes are you most involved with or knowledgeable about and would be comfortable discussing today?

4. Could you please describe the key roles and responsi bilities of these cadres with respect to the provision of maternal, newborn, reproductive, and child health services?
    a. How would you describe the effectiveness of these CHWs currently in fulfilling their RMNCAH roles and responsibilities?

    Probe for:
        i. any other roles and responsibilities these RMNCAH CHWs might have: immunization/ polio, nutrition &/ECD, disease surveillance, WASH and/or disaster response, etc.
        ii. to determine if RMNCAH roles and responsi-bilities are spread across a number of cadres and how these cadres are coordinated.

    b. What factors facilitate and what factors constrain
    their effectiveness in fulfilling their RMNCAH roles and responsibilities?

    Probe for:
        i. What facilitating factors should be retained
        ii. Factors related to the individual CHW, the community and the health systems
        iii. Any gender related constraints to CHW effectiveness
        iv. Any other equity related constraints such as caste
        v. Any constraints related to competences and availability of supervisors
        vi. Recommendations to overcome these constraints.

Thoughts on how the RMNCAH roles and responsibilities of these CHWs might change in the next 10 years.

During our desk review we identified the following key findings related to health system support (explain/provide definition) for these CHW cadres. Do you agree with these?

Discuss any country specific issues identified through the desk review related to:

i. Selection, education & certification
ii. Management and supervision, including remuneration, contracting and career ladders
iii. Integration with health system and communities, including target pop size, data collection and use, community engagement, and availability of supplies
iv. Gender
v. Leadership and Governance

Probe for key strengths and weaknesses of the system support for these CHWs when discussing these findings.

5. What system support improvements do you think are needed to optimise the roles and responsibilities of these CHWs to better serve maternal and newborn health?
   a. How would you prioritise these?

6. During our desk review we identified the following gaps in the information we reviewed. Do you agree with these gaps? Could you provide any information or recommend any sources of information to address these gaps?

   Provide a summary and discuss key information gaps identified through the desk review (see country snapshot summaries)

7. Is there a database/HR information system in place and maintained for CHWs in (name the country)?
   Probe for:
   i. for which cadre are data collected
   ii. the type of information collected (e.g. name, sex, age, location , cadre, training, funding source)
   iii. how the information is used
   iv. ownership and maintenance of database

8. Could you recommend any sources of information to address these information gaps?

B. Policy environment for CHW programmes

1. From the list of policy documents that we have, are there any other key policies or strategic frameworks that guide CHW programmes in (name the country)?

2. How well do the policies support the implementation of programmes related to these CHWs and the achievement of results? What are the policy gaps? Probe for any challenges to effectively translate policies into results.

3. Are there any plans to strengthen or reform programmes related to these CHWs in (name the country)? (Please describe)

   Probe for:
   i. changing roles in RMNCAH
   ii. changing roles in primary health care
   iii. competing roles with non-communicable diseases
   iv. improved information systems
   v. changing nature of demographics/community structures that is likely to influence any changes in the CHW roles and responsibilities
   (i.e. due to patterns of regional or national migration/outmigration, security concerns, labour market demands etc.)

4. Are there any plans to strengthen or reform primary health care services in (name the country)? (Please describe). Draw on any country specific information from desk review findings.

   Probe for:
   i. the impact of reforms on the roles and responsibilities of these CHWs
   ii. any ongoing or planned reforms related to Astana or Universal Health Coverage

5. What policy improvements are needed to optimise the roles and responsibilities of these CHWs to:
   a. provide RMNACH services
   b. respond to Post Astana or PHC reforms?
   c. How would you prioritise these?

6. In your opinion, what do you think are the key challenges to strengthening or reforming programmes related to these CHW in (name the country)?

   Probe for the following:
   i. systems support issues
   ii. unclear roles and responsibilities
   iii. lack of policies
   iv. governance and leadership
   v. financing/resources
   vi. technical capacity
   vii. Lack of coordination

C. Gender

1. What role does gender play in the design and implementation of programmes related to these CHW in (name the country)? (Contextualise the probes based on desk review findings)

   i. Female and male CHW roles in the provision of services and take up of services by communities
   ii. CHW selection criteria for different CHW roles- RMNCAH, immunization/polio, nutrition, &/or ECD 0-3, other disease surveillance, WASH

and disaster response
iii. Community acceptability
iv. Effectiveness of CHWs in carrying out their roles and responsibilities
v. Access to training
vi. Discrepancies between prescribed coverage area/target population and what happens in practice due to HR/CHW shortages
vii. Work environment and safety
viii. Remuneration
ix. Senior/leadership roles
x. Career progression opportunities/criteria and constraints
xi. Overcoming potentially prohibitive cultural norms
xii. How other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs

2. Of the gender issues related to these CHWs that you have identified, how are these being addressed?

Probe for policies and specific system support

D. Financing and resource mobilisation

1. How are programmes related to these CHWs currently financed and/or resourced?

Probe for information on the following funding streams and proportion of funding from each:
i. Government financing
ii. Donor projects/programmes (off budget)
iii. Direct budget support from donors
iv. Community resources
v. Support from NGO and private not-for profit organisations
vi. Support from private-for-profit organisations

Request any documentation to support responses

2. Are there any changes planned to financing strategies for programmes related to these CHWs and/or to improve system support?

Probe for the following:
i. increased domestic or external funding;
ii. private sector support/involvement
iii. new mechanisms for health financing (user fees, health insurance,...),

Probe for availability of financing for CHW system support including:
i. drugs and medical supplies,
ii. remuneration
iii. job aids
iv. transport and logistics support
v. IT equipment for data collection
vi. supervision and mentoring
vii. refresher training

E. Private Sector Contribution to CHWs

1. What is the private sector's contribution to the production, use and management of these CHWs in this country?

Probe for:
i. Participation of contribution of not-for-profit and for-profit private sector organisations
ii. participation of private training institutions in training these CHWs
iii. participation of health professional societies in training these CHWs

2. How could the contribution from the private sector be enhanced?

Additional information:

- Which key stakeholders would you recommend we meet while we are in the country?
- Are there any key documents that we should review for this study?

Closure

- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

Annex 2 Key informant interview guide on GENDER for national level stakeholders

Potential informants: Informants with a special knowledge/work area of gender and CHWs – including UNICEF CO gender focal person, any gender focal persons with different ministries involved with CHWs, gender focal persons from development partners, representatives from NGOs working on gender and health.

Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders on gender issues in policies and programmes related to CHWs.
- Ensure participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheet, consent form, note on country-specific gender issues identified from desk review; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration

Please include the following details and participant profiles as part of the recording:

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organisation
- Number of months/years working in this position

For example: 'This is an key informant interview in Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'.

1. Please describe briefly your current position and your work, current and previous, related to gender and CHWs.

2. In your experience, in this country (name the country), how do you think gender impacts on the work of the CHW cadres we have identified in this country (name the cadres or provide list of the cadres we are referring to)?

   Probe for:
   - I. Gender issues faced by these CHWs
     - i. at family/household level
     - ii. in the community
     - iii. within the health system
   - II. Challenges faced by these CHWs in their work due to these issues

3. You spoke about how gender impacts the work of CHWs. How do other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs?

4. At the policy level how does gender play a role in policies related to these CHWs in this country (name the country)?

   Probe for:
   - I. Selection of CHWs for training
   - II. Division of roles/services between male and female CHWs
   - III. Remuneration
   - IV. Career progression
   - V. Work environment and safety
   - VI. any focus in CHW/PHC policy on gender issues related to other genders (apart from male/female, eg. transgender) and any suggestions on how these can be included

5. At the programme level how does gender play a role in in the design and implementation of programmes related to these CHW cadres in this country (name the country)?

   Probe for:
   - I. Female and male CHW roles in the provision of RMNCHAH services by the health system and take up of services by communities
   - II. CHW selection criteria
   - III. Access to training
   - IV. Work environment and safety
   - V. Mobility
   - VI. Remuneration
   - VII. Senior/leadership/supervisory roles
   - VIII. Career progression
   - IX. Overcoming potentially prohibitive cultural norms

6. Have any specific policy measures been put in place to ensure that policies and programmes related to these CHWs are gender responsive/address issues related to gender?

If necessary, explain that gender responsiveness involves
considering gender norms, roles and inequalities, and measures to actively address them.

Refer back to issues raised as part of previous questions. Probe for answers from Q2 i, ii, iii, and Q3 if any solutions were given).

Probe for:

I. What are the key successes of these measures in addressing gender concerns in the CHW policies/programmes?
II. What are the key challenges of these measures in addressing gender concerns in the CHW policies/programmes?
III. Can you cite any specific examples of CHW programmes in the country where policies or programmes have been/have made efforts to be gender transformative?

If there are any issues identified in the desk review around gender for this specific country, refer to these and ask if anything has been done to address them.

7. If programmes related to these CHW in this country (name the country) were to be made truly gender transformative, what would you suggest should happen to achieve this?

If there are any issues identified in the desk review around gender for this specific country, refer to these and ask if anything has been done to address them.

Probe for:

I. Anticipated barriers, challenges and suggested solutions in implementing these suggestions
II. Equal pay
III. Equal access to training
IV. Equal access to promotion opportunities
V. Overcoming cultural norms/barriers

8. With regards to community health and/or PHC reforms being planned in this country (name the country), what are the measures being put in place to make programmes related to these CHWs responsive to gender concerns?

I. What would be your suggestions to make them more gender responsive?
II. Anticipated barriers, challenges and suggested solutions in implementing these suggestions

Additional information:

- Which key gender informed stakeholders would you recommend we meet while we are in the country (name the country)?
- Are there any key gender related documents that we should review for this study?

Closure

- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

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