Strategic Directions for Strengthening Community-based Health Workers and Community Health Volunteers in the South-East Asia Region

World Health Organization
Regional Office for South-East Asia

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1. Introduction

The World Health Organization (WHO)'s South-East Asia (SEA) Region has a rich history in terms of community health action that can be traced back to 1926, when the first Community Health Unit was established in Kalutara, then a small town in Sri Lanka. A study of this history reveals that since then many countries in the SEA Region such as India, Myanmar and Thailand have practised different types of community-based health activities that are facilitated by a community-based health workforce depending on each country's requirements. Almost all Member countries of the Region practised many elements of primary health care that were later packaged into the PHC approach, which was formally introduced in 1978 in the form of the Alma Ata declaration.

It has been 30 years since the Alma Ata Declaration on Health for All (HFA) through Primary Health Care[1] (PHC). Since then, many categories of government and nongovernment primary health care workers have been working in communities, undertaking varied roles contributing to community health action in one form or another. In 1978, with introduction of the PHC approach, a number of fundamental principles of health development were identified as essential to the attainment of HFA. The PHC principles that are the most practised and emphasized are "community participation" and "self-reliance in health". In almost all countries, health workers working closely with communities have been in the forefront, bringing about community participation in health.

Most countries in the Region scaled up their community health programmes to national level by the late 1980s[2]. The rapid expansion of community-based health workers (CBHWs) that was seen during the initial years after the Alma Ata Declaration did not last long enough in many countries of the Region to bear fruitful results. What caused the dismantling of the community health workforce still remains unclear - whether it was lack of commitment and focus on the PHC concept or lack of dedicated, motivated and competent community health workforce that contributed to the desegregation of the PHC concept.

The need to revitalize the PHC approach in the Region gained significance under circumstances that showed that some Member countries may fall short of achieving the health-related Millennium Development Goals (MDGs) and other regional goals. It is believed that revitalizing such an approach would be constrained by the shortage of PHC workers, as many countries in the Region are already facing a severe shortage of health workforce to ensure essential health interventions. Internal migration of health workers too attributes to the shortage which is felt mostly in rural areas. There is therefore a need to ensure that this shortage is filled with appropriate categories of health workers working in the community who can facilitate the provision of primary health services even to the unreached population.

With the objective of advocating among Member countries the idea to invest in a strong, motivated, dedicated and equitably distributed PHC workforce in the Region, so as to revitalize the PHC approach, a regional consultation was organized in Chiang Mai, Thailand in October 2007 on Revisiting Community-based Health Workers and Community Health Volunteers (CHVs). The meeting brought together over 100 representatives of Member countries from different backgrounds who discussed the need to focus on developing a well-trained community-based health workforce to bridge the acute shortage of health workforce in the Region.

As an outcome of the meeting, in January 2008, a document on Strategic Directions for Strengthening Community-based Health Workers and Community Health Volunteers in the South-East Asia Region was developed. The rich inputs provided by the consultation were incorporated into the document, which in turn was peer reviewed in February 2008 by experts from Bangladesh, India, Indonesia, Nepal and Thailand.

The document attempts to define the strategic directions that Member countries of WHO's SEA Region may adopt to utilize the inherent strength of community-based health workforce and thereby address some of the health issues and challenges faced by many of them. These workers have the potential of not only increasing the access to marginalized sections of society to health care but also to serve as a bridge between families, communities and health services. With increasing levels of literacy and health acceptance in countries leading to increasing health demands, it has become clear that these categories of community-level health-care workers would be an asset to all Member countries in the Region.

2. The need to revisit community-based health workers and community health volunteers

Thirty years after the Alma Ata Declaration many countries of the Region are still struggling to ensure adequate and equitable health service coverage to their populations. The rapidly changing priority health needs of countries fuelled by a number of critical factors from within and outside the health system have challenged the functioning of health systems of many countries.

Many countries in the Region are undergoing demographic transition. The increase in middle-aged and elderly population is directly and indirectly changing the landscape of health needs and demands. The epidemiological transition in countries, which is partly affected by demographic changes, too shows a change in disease patterns. While countries in the Region are still attempting to reduce the burden brought about by communicable diseases, the burden from chronic and noncommunicable diseases, injuries and road traffic accidents as well as health effects of climate changes are causing a double burden that many countries cannot bear. The rapid socioeconomic development of countries has witnessed urbanization, rise in

living standards leading to increased expectations of population and internal migration of health workforce leading to increase in health needs in urban as well as remote areas, all of which have created a need for health workers both in rural and urban areas. The technological advancement including advancement in information technology, seen over the past two decades has increased the demands and expectations of service seekers, at the cost of health services.

The cost of health care influenced by issues mentioned above is sky rocketing. Amidst all these challenges, governments are under pressure to scale up health interventions covering all segments of the population, while maintaining good quality health services at an affordable cost. PHC is likely to be an effective and affordable strategy to ensure equitable access to preventive, promotive and curative health services for existing and emerging health problems and challenges.

It is in the light of these experiences, as well as the changing socioeconomic and political dimensions over the last 30 years that the need to revisit the CBHWs and CHVs has arisen. The strategic document focuses more on the development of CBHWs and CHVs within the changing environment, keeping in mind that the experiences of a strong community-based health workforce could be effectively and efficiently applied to benefit resource-depleted settings.

The past experiences of countries in the Region show that a community-based health workforce will play a dual role - filling the gap of health workers and empowering the community. According to the report of the Joint Learning Initiative (JLI)[3] and the World Health Report 2006[4], the development of CHVs (referred to as Community Health Workers in the World Health Report) is a strategy that needs to solve the crisis that has occurred due to the acute shortage of human resources faced by most developing countries including countries of the Region under the present trend of globalization. Learning from the rich experiences of the Region, it is clear that the rationale and the logic for development of a community-based health workforce includes much more than being a "stop-gap measure". The same also introduces an "empowerment and participation" philosophy, i.e. CBHWs and CHVs as a means to empower communities and individuals so that they become active partners in health promotion and disease prevention in the community rather than mere "stop-gap" service providers[5].

2.1 Community health action

Over the past few decades, with increasing health challenges, the importance of community health action has been highlighted as never before. In this process the community assesses its own needs and resources and comes up with a plan to address its health concerns. These can range from improving water supply and sanitation facilities to services for maternal and child care and controlling communicable diseases, etc. Scaling up community health action through a dedicated and motivated community health workforce has been proven as an effective and cost-efficient strategy to achieve better health outcomes by several countries in the Region. This goes hand in hand with the reorientation of the health system and its health workers to work differently and more effectively with the community[6], and within the community not only in decision-making for health, but also in creating a seamless interface with the community.

The main players for community health action are those health workers who work closely with communities, and who are from the community itself.

The SEA Region has witnessed significant innovation in PHC, especially with regard to community participation in health. A number of models have been developed, tested and found to be successful in different areas and communities. These models have been shared with other countries and modified, as appropriate, by countries and even by other regions[7,8]. Although economic growth and increased per capita income that lead to greater expendable income and investment in health have increased gradually in most countries, the emphasis on community participation in health has always been one of the main features of health systems in countries in the SEA Region.

2.2 Community-based health workers and community health volunteers

The terminology that is currently being used to refer to health workers who work closely with communities, promoting community health action varies significantly from country to country. The relevant literature refers to this category in many terms, such as field health workers, community health volunteers and community health workers, etc. Even though many variations of this terminology still exist among Member countries, this document attempts to define these categories that will in turn facilitate a common understanding among all Member countries.

Health workers are defined as "all people engaged in actions whose primary intent is to enhance health"[4]. They include all workers who are working in health and non-health sectors based either in institutions or in the community but working with the primary intent of improving the health of either individuals or communities. The rich and diverse experiences gathered from Member countries clearly show that it may not be possible to include all categories of people who are working in the community with the intention of improving health within the given definition even though they are an important link between people and health services. Some of these categories may include members of local administrative units and different civic groups in communities such as faith-based organizations and traditional healers, etc. which vary from country to country. It is therefore important for each country to identify the different groups of health workers as part of the community-based health workforce in order to suit each country's experience.

Even though there are many categories of the community-based health workers carrying out a wide range of functions in Member countries, WHO's Regional Office for South-East Asia makes an attempt to categorize them under two broad categories: CBHWs and CHVs.

Community-based health workers (CBHWs): All health care workers who are part of the formal health organization, and have undergone formal training to carry out a series of specified roles and functions, and spend a substantial part of their working time actively reaching out to the community, discharging their services at the individual, family or community level. These may include doctors, nurses, midwives who fulfil the above criteria, public health inspectors, health attendants, health supervisors and family health visitors, etc. who spend a substantial part of their working time actively reaching out to the community.

Community health volunteers (CHVs): Members from communities often selected by communities themselves and answerable to them, and who have undergone shorter training than professional workers. They are not salaried, but may receive financial and other incentives. They are predominantly involved in health promotion and prevention of health problems, and are supported by the community and the health system but are not necessarily a part of a formal organization. In some countries these CHVs are basically village members who work on a voluntary basis and are called village health volunteers. In specific settings such as post emergencies these categories could be rapidly trained and employed to provide very basic health services and to assist the trained health care workers in service delivery. There could be several variations in this category such as "village health communicators" in Thailand who are trained to carry out health education and communication of key messages.

There are many other categories of health workers who work closely with communities, responding to their health needs and demands, such as spiritual healers, traditional healers, indigenous medical practitioners and quacks, etc. Respective Member countries should take appropriate action to develop their services within the specific country policies and regulations.

2.3 Key features of future strategic development

Based on past experiences and the lessons learnt, some key features that may need to be taken into account for future strategic development can be summarized as follows:

(1) Community-based intersectoral action for health is essential to achieve optimum growth of health services for sustainable health development and should not be taken only as a temporary measure to fill service gaps.

(2) Community-based action for health comprises actions beyond merely providing health services to community members. They encompass a broad spectrum of roles and functions of various types of health workers that include but are not limited to CHVs and CBHWs in the service system.

(3) Countries in the Region have taken steps as well as created policy frameworks that will gradually integrate CBHWs and CHVs into the overall health system development.

2.4 Renewal of political commitment and WHO's response

The political commitment and WHO's response to build strong community health action in Member countries can be traced back several decades. The Regional Office organized a technical discussion on Community Actions for Health at the forty-sixth session of the Regional Committee for South-East Asia in 1993. The Committee looked beyond the health sector in order to create a broader and sustainable spectrum of community actions for health[9].

The landmark Calcutta Declaration (1999) adopted at the Regional Conference on Public Health in South-East Asia endorsed the need to strengthen and reform public health action through health-care workers that include ancillary health workers and volunteers. This led to the development of the Public Health Initiative in the Region[10].

The Public Health Initiative, which emphasizes the need to ensure a range of public health functions through a well-trained public health workforce including CBHWs has been another important milestone in the Region's history.

Most countries in the Region are well aware of the challenges they face in relation to scaling up essential health interventions to reach the unreached. Many countries have witnessed a resurgence of community action through past experiences, especially after the HFA declaration. The need to intensify community-based health action has been endorsed repeatedly by many countries at several regional and intercountry meetings.

The commitment of Member countries of the SEA Region in ensuring a competent, motivated and equitably distributed health workforce, and to scale up low-cost essential health interventions with proven efficacy manifested itself when the Health Ministers of Member countries made a declaration in Dhaka, Bangladesh, in 2006 on strengthening the health workforce in countries of the Region.

The Regional Office's action on strengthening health systems through health workforce development received the highest priority as a result of the 2006 declaration. The Dhaka Declaration of Health Ministers of the Region, resolution SEA/RC59/R6[11] of the Regional Committee on strengthening the health workforce in the Region, and the Regional Strategic Plan for Health Workforce Development in the South-East Asia Region[12], which was endorsed by the fifty-ninth session of the Regional Committee, have been the landmark events in the Regional Office's recent history. Realizing and recognizing the pivotal role played by CBHWs and CHVs in improving the health outcomes especially among the underprivileged, the Regional Office has decided to develop the publication: "Strategic Directions for Strengthening Community-based Health Workers and Community Health Volunteers in the South-East Asia Region."

3. Guiding principles

While attempting to revisit the concept of institutionalizing CBHWs and CHVs, it is important to understand the following key values and guiding principles:

(a) **Equity:** Development of a range of effective, community-based actions for better health outcomes in an equitable manner is to be given priority. It is proposed that health-care workers working at the grass-roots level and providing services to populations and settings that have suffered from health inequities be given adequate recognition and utmost priority.

(b) **Community empowerment:** In many countries, communities are often not empowered to participate in decision-making in relation to their health matters. Often they lack skills if not knowledge, and also lack the opportunity to learn from health actions. The principle of empowerment demands that communities are provided with opportunities to learn and decide on the course of actions they see fit for themselves.

(c) **Participation and partnership**: Participation and partnership in health development is a crucial principle that underlines the development of CBHWs and CHVs. They should be seen as partners carrying out their actions for their communities rather than service providers from whom services are purchased.

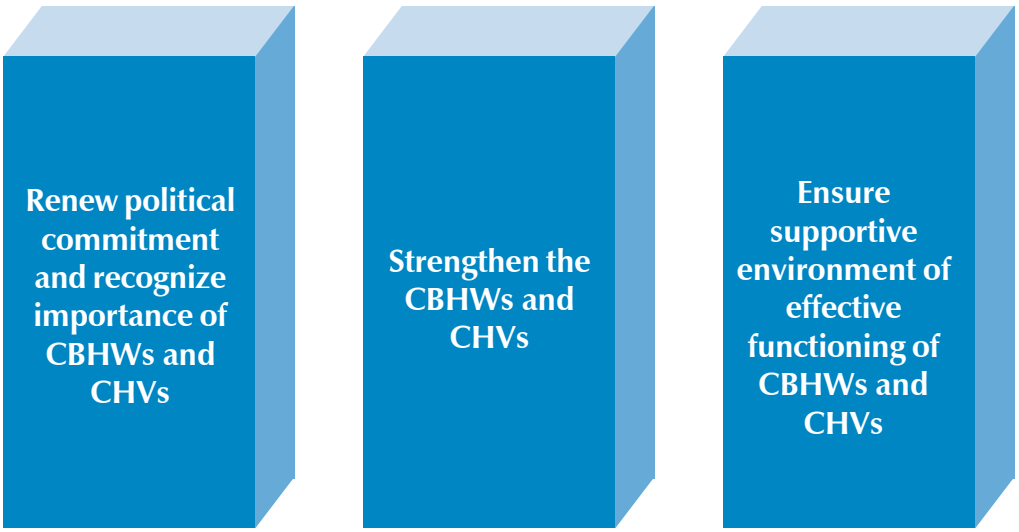
(d) **The evidence base:** During all stages of the development process, it is recommended that decisions are based on sound evidence, whenever available. This goes hand-in-hand with increasing the capacity to generate evidence and translating it into sound policies, programmes and practices.

(e) **Good governance:** The systematic development of CBHWs and CHVs is required to be based on the health needs and demands of decentralized units, closely woven with the local governance mechanisms.

(f) **Values:** Health is to be explicitly recognized as a fundamental human right and utmost care needs to be taken to accommodate cultural diversity and social norms while minimizing gender imbalances during all stages of development.

4. Strategic pillars of development of community-based health workers and community health volunteers

There are three pillars on which the development of CBHWs and CHVs rests upon. They encapsulate the past experiences of the community-based health workforce movement and take into account the changing environment as well as the principles which are critical for the success of scaling up essential health interventions to reach the unreached through development of a competent, motivated and equitably and strategically placed CBHWs and CHVs.



1. **Renew political commitment and recognize the importance of CBHWs and CHVs:** The identification of the need for CBHWs and CHVs, their different roles and functions, based on the current and future health needs and demands of countries and communities would provide the policy support and opportunity to strategically place them within the health system and to enable them to play their facilitating role, thereby supplementing national efforts to produce better health outcomes. The broad strategic actions are:

    - Develop/review policies, regulations and legislation favourable to community health actions in line with PHC; and
    - Map out the health workforce requirement for delivery of community health actions.

2. **Strengthen the CBHWs and CHVs:** The need for CBHWs and CHVs would trigger off a series of strategic actions that will lead to a continuous evolution of CBHWs/CHVs as a system. It is important to focus on strategic actions with the assumption that these workers form an integral part of a well-functioning health system.

The broad strategic actions are:

- Capacity building of CBHWs and CHVs, based on the health needs and demands in a changing environment;
- Develop effective incentive schemes and motivation mechanisms;
- Create local ownership and partnership; and
- Maximize the support from district/sub-national health systems to accommodate CBHWs and CHVs as part of the health system.

3. **Ensure a supportive environment for effective functioning of CBHWs and CHVs:** Often the health sector has less control over the environmental factors that enable the effective functioning of CBHWs and CHVs. However, the goal of creating community-based actions through CBHWs and CHVs with effective community participation in health needs to take place within certain favourable socio-political environments. Thus, the need to develop a supportive environment.

The broad strategic actions are:

- Ensure an adequate legal and administrative framework for improving the working environment of CBHWs/CHVs;
- Strengthen the local/district administrative structures to harness the synergies of CBHWs/CHVs actions; and
- Develop healthy community values among societies for community health action.

5. Strategic actions

This section will provide nine broad strategic actions that are proposed for countries of the Region to adapt or to adopt. Each action is described here briefly, and followed by a few key action points that are proposed for implementation by Member countries and by WHO.

Strategic action 1: ***Develop/review policies, regulations and legislation favourable to community health actions in line with PHC.***

Community-based actions in a particular country will depend, inter alia, upon several factors including national and sub-national political commitment, policy environment and the country's existing regulations and legislations. While political commitment has already been expressed in both implicit and explicit terms by all Member countries, the need still exists there to operationalize it through a favourable policy framework.

In order to ensure that CBHWs and CHVs can carry out their roles and functions in the most effective and efficient manner, every government has a role to ensure that they work within a favourable regulatory and legislatory environment. While all countries have their own regulations and legislations, it is important that steps are taken to ensure that the existing policies, regulations and legislations by no means hinder the responsibilities of CBHWs and CHVs.

Action by Member countries
• Develop, review and update national health policy through consultative processes on PHC with specific focus on community-based action and involvement of CBHWs/CHVs, based on evidence. • Develop, review and update existing regulations/legislations to empower CBHWs/CHVs to perform their work effectively in a changing environment. • Develop a country database of all relevant policies, regulations and legislations and make it publicly accessible.

Action by WHO

- Technically support countries to develop favourable evidence-based policies, regulations and legislations.
- Facilitate the consultative process and create regional alliances for policy and practice regarding CBHWs/CHVs and community-based action.
- Develop a regional database with policies, regulations and legislations of Member countries in relation to community health action and make information/database available to countries.

Strategic action 2: ***Map out the health workforce requirement for delivery of community health actions.***

Depending upon the results of Strategic Action 1, countries will need to map out the requirement of CBHWs/CHVs. Many existing public health programmes take a vertical approach in providing community-based health action. Examples include family planning workers, community-based midwives, malaria-linked volunteers and the proposed kala-azar activists, while others adopt a more universal approach in involving community-based workers (multipurpose workers).

While mapping, it would be important to consider that in most countries there are several workers at the community level, not normally categorized as 'community health workers' who can play important health-related functions. These include those working in the area of nutrition, water and sanitation, vector control and community development, etc. Based on prioritization, countries may decide what additional health-related roles this category of community-based workers can play.

The epidemiologic and policy context in countries will determine what role the above-mentioned categories can play in public health initiatives.

Action by Member countries

- Critically review the process and outcome of CBHWs/CHVs to identify best practices of community health actions.
- Identify the current/emerging public health problems that could be effectively strengthened by community health action.
- Identify the different types of CBHWs and CHVs required to address the health challenges.
- Map out the available community workforce (both health and health- related) in administrative/geographic units in the country and identify shortfall, if any.
- Identify underserved areas and vulnerable groups and specifically define the role of CBHWs/CHVs in these areas.
- Identify community workers, not categorized as CBHWs/CHVs, who can be involved in community health action.

Action by WHO

- Document the examples of best practices of CBHWs/CHVs with regard to their involvement in community health action, and disseminate those to Member countries.
- Provide technical guidance and support to Member countries to prioritize areas of involvement of CBHWs/CHVs by developing a set of evidence-based norms.
- Develop and share tools and guidelines and provide training for mapping the community health workforce.
- Generate evidence (operations research) about the effectiveness or otherwise of the role of CBHWs/CHVs in community-based health action in the Region.
- Support regional partnership and inter- country cooperation for strengthening community-based heath action.

Strategic action 3: ***Capacity building of CBHWs and CHVs based on health needs and demands in a changing environment.***

The capacity development and empowerment of future CBHWs and CHVs to function as effective change agents of the community need more innovative training and re-training approaches. The identification of key competencies that include the ability to identify priority health problems and target populations, and integrating them into local resources requirements (human, financial and social capital) needs to be given priority rather than limiting the training to merely technical know-how of various diseases and health risks. Opportunities for in-service training need to keep pace with the rapidly- changing training needs.

Action by Member countries

- Develop/streamline the job descriptions of CBHWs and CHVs to enhance their role in the changing context.
- Assess the pre-service and in-service training needs for each category, based on key competencies, and to develop a training master plan.
- Develop, review and update the pre-service and in-service competency-based community-oriented curricula for CBHWs/CHVs.
- Develop a set of standards for training facilities and ensure quality assurance mechanisms.
- Strengthen and develop training facilities and human resources/trainers, if needed.
- Provide pre-service, in-service and refresher training and promote continuing education systems to make the CBHWs/CHVs competent to face the changing environment.
- Develop capacity to carry out educational and operational research on training of CBHWs and CHVs.

Action by WHO

- Develop tools to identify training needs of CBHWs and CHVs and make them available to countries.
- Develop guidelines for quality assurance at training institutions and facilitate introduction of quality control mechanisms in the training of CBHWs/CHVs.
- Support multi-country/centre research while building country capacity for research.
- Support research and development of community-based in-service training, and disseminate the best practices among Member countries.

Strategic action 4: ***Develop effective incentive schemes and motivation mechanisms.***

Effective incentive and motivation (financial and non-financial) mechanisms are important factors that help in the development of CBHWs and CHVs for sustainable community health action. The package may vary from one country to another and from one locality to another. Based on the local context, it is important to put in place proper financial incentives for the work of CBHWs and CHVs. This involves the need to decide on how CBHWs and CHVs could be integrated into the formal health system and paid through a formal mechanism like in the case of other health professionals. In some countries, CBHWs are considered as "full and formal" government employees like other health personnel.

Besides financial incentives there also are the issues of recognition and partnership. Though essential, these are more difficult to put in place although these entail no financial implication.

Action by Member countries

- Conduct studies to explore/plan/ monitor and evaluate the job motivation and incentive schemes of CBHWs/CHVs, both financial and non-financial.
- Develop simple and fair compensation protocols.
- Develop national and local merit/awards recognition system for CBHWs/CHVs.
- Develop career ladders for CBHWs.

Action by WHO

- Support Member countries in conducting analysis of motivation mechanisms and incentive schemes.
- Document and share among Member countries the experience on incentive schemes and motivation mechanisms for CBHWs/CHVs, from both within and outside the Region.

Strategic action 5: ***Create local ownership and partnership.***

The sustainability and stability of community-based actions for health can be ensured only if CBHWs and CHVs remain part of the community, supported by the local administration or the community itself. Although the development of CBHWs may be initiated through the health sector, the community must accept and take ownership/partnership of developing their management capacity and other supportive functions. Creating a common vision with various groups of local administration and communities is a critical step towards creating local ownership or joint partnership towards community development for health.

Action by Member countries

- Enforce legislation and regulatory mechanisms for CBHWs/CHVs, development and community financing.
- Implement operational tools/guidelines for CBHWs/CHVs development and community financing.
- Carry out advocacy to acknowledge the important role of CHVs in the formal health system.
- Advocate for involving the local government with sufficient budget and strong policy to promote CBHWs/CHVs.
- Organize leadership development training for local administration to play an active role in supporting CBHWs/CHVs as part of local health development efforts.
- Promote inter-sectoral collaboration between ministries and non-governmental organizations at different levels towards community ownership in CBHWs/CHVs' development.

Action by WHO

- Advocate with governments, particularly with health ministries for greater resource allocation to facilitate local ownership/partnership in CBHWs/CHVs' development.
- Facilitate experience-sharing among countries on local government involvement in promoting CBHWs/CHVs.
- Develop tools to evaluate and analyse the community-based health workforce situation in communities.

Strategic action 6: ***Maximize support from district/sub-national health systems based on PHC.***

Health-care workers within a district health system, including those from the curative sector are critical in achieving good health outcomes. Their roles are multiple and include monitoring and promoting certain types of actions and approaches carried out by CBHWs, as well as promoting the image of CBHWs to broader groups of stakeholders in the society. They are also required to work proactively as mediators/coordinators to facilitate their work with other sectors in the community and with other partners such as NGOs that are working in the community.

Action by Member countries

- Re-orient health personnel from ministries, universities and other partners of health systems to understand the vision and goal of CBHW development/strengthening.
- Organize leadership development training for health personnel to provide effective leadership to create the trust and partnership needed for long-term engagement and collaboration from CBHWs, as well as from other strategic partners.

Action by WHO

- Advocate to governments, particularly health ministries to involve CBHW development as part of the provincial, district and sub-district health systems.
- Develop training modules for health personnel in mentoring and promoting CBHWs and facilitating with other sectors in the community for community health development.

Strategic action 7: ***Ensure adequate legal and administrative framework for improving the working environment of CBHWs/CHVs.***

The goal of creating CBHWs/CHVs and community-based actions for health to allow sustainable and effective community participation in health, needs to take place within a favourable socio-political environment. A strong national policy that supports the roles of CBHWs and CHVs, as well as a favourable legal and administrative framework play an important part in the development and sustainability of community action.

A strong local administration is seen as an active partner in CBHW development and management while a weak administration would weaken the development of the CBHW movement. Such strengths or weaknesses are partly structural and if the policy and design of decentralization are not favourable, the capacity-building efforts would be rendered ineffective, if not impossible. High level policy support for the role of the community, as well as for community participation in health is possible even within a highly centralized political environment. However, it will require a strong leadership to implement such a policy.

Action by Member countries

- Ensure implementation of legislation and regulatory mechanism for improving the working environment of CBHWs/CHVs.
- Develop district- and subdistrict-level policies and administrative framework to facilitate the work of CBHWs/CHVs.
- Formulate district- and subdistrict-level action plans to develop community-based health action and CBHWs/CHVs.
- Develop a code of conduct, taking into account the local customs, for each category of CBHW/CHVs.
- Encourage local-level advocacy to influence the framing and compliance of laws.
- Develop mechanisms for effective monitoring and supportive supervision, and provide technical support.

Action by WHO

- Provide technical assistance to Member countries to develop/ strengthen their policies and legal administrative framework at local levels.
- Provide technical support to countries to develop district, sub-district strategic/action plans for community-based health workforce development.

Strategic action 8: ***Strengthen local/district administrative structures to harness the synergies of CBHWs/ CHVs' actions.***

Ensuring effective and continuous support from the local (district) health systems is mandatory for effective functioning of district-based community health action. Whether or not it is desirable or possible to establish local ownership or joint partnership in development and management of CBHWs within the health system remains an important aspect in achieving a well-functioning community-based health workforce.

In order to provide such support effectively and continuously, a two-pronged action is required. The first deals with re-orientation of human resources so that health personnel, especially those at the local level understand the vision and goals of developing CBHWs so that they do not see them as only another pair of helping hands. The second action deals with ensuring adequate logistical support for the work of CBHWs and CHVs and building up the required capacity and infrastructure for this purpose.

Action by Member countries

- Establish/strengthen a unit/focal point responsible for CBHWs and CHVs at the district level.
- Re-orient health-care workers at district level to understand the potential of CBHWs and CHVs.
- Ensure adequate logistical support for the work of CBHWs and CHVs.
- Establish a multi-sectoral committee or forum to enhance communication, coordination and mobilize adequate resources in support of CBHWs/CHVs.
- Delegate the financial and administrative authority to the local level to manage action through CBHWs and CHVs.

Action by WHO

- Develop guidelines on strengthening local/district administrative structures to harness synergies of CBHWs/CHVs' action.
- Provide opportunities for exchange of experience among Member countries and WHO on support mechanisms for CBHWs and CHVs.
- Harmonize and simplify the UN and other donor inputs for health development, including at the district level.

Strategic action 9: ***Develop healthy community values among societies for community health action.***

A society's values regarding health and medicine, its attitude towards active participation and the role of its members as active citizens are some of the societal attributes that would ensure development and sustainability of a strong community-based programme.

Societal values that favour medical services over health promotion and place a greater value on highly trained personnel such as doctors and nurses would prevent CBHWs and CHVs from playing their stipulated roles and functions. Such values will certainly create impediments to integrating community-based actions for health into the national health system. Health promotion and preventive services are as important as medical services. The roles and responsibilities of CBHWs and CHVs working in a team with highly trained personnel such as doctors and nurses should be emphasized.

Action by Member countries

- Make use of the positive existing community values and customs in promoting community-based action through CBHWs/CHVs.
- Carry out advocacy to address the inequity in health and strengthen community empowerment.
- Ensure adequate governance mechanisms and accountability in the health sector.

Action by WHO

- Provide technical assistance to countries to develop healthy community values.
- Provide technical assistance to countries to design and carry out advocacy programmes.

6. Way forward

Revisiting the concepts and practices of development of CBHWs and CHVs has shown that community-based actions for health are still relevant and critical for the health development of Member countries, especially in achieving MDGs. Some countries have been able to integrate these actions fully into their health systems, with CBHWs playing an integral part of service provision, while other countries are yet to develop such systems.

The need to develop this document: "Strategic Directions for Strengthening Community-Based Health Workers and Community Health Volunteers" arose as a result of a policy direction of the Regional Office to focus on revisiting PHC as an approach to strengthen health systems of Member countries. This document is based on the belief that community-based actions for health, and CBHWs and CHVs are essential components of a health system, and that CBHWs/CHVs should not be seen and used only as a temporary stop-gap measure, waiting to be replaced by more qualified health personnel.

Responsibility of implementation

There are two important players who bear the responsibility of implementing the strategic actions listed in the document. Implementing country activities is the responsibility of national governments and local governments, NGOs, civil societies and organized communities as they in turn will collectively contribute to the regional action. The Regional Office with the assistance of WHO country offices and WHO headquarters will be responsible for implementing the specific activities that have been identified for WHO.

While implementing these activities, the challenges to be faced by respective Member countries cannot be undermined, as CBHWs and CHVs, if appropriately placed, would play an anchoring role in communities, catalyzing community participation and involvement, while maximizing the involvement of other community development organizations.

Partnership and coordination

Partnership and coordination in the effective implementation of a strategic plan is critical for its success. Global and regional partnerships and networks can play an active role in assisting Member countries in the development of CBHWs and CHVs. Building on the rich cultural and social diversification seen among Member countries in the Region, partnerships and networks can facilitate the sharing of knowledge and practices in relation to community-based heath workforce development.

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