Policy brief for Maldives

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

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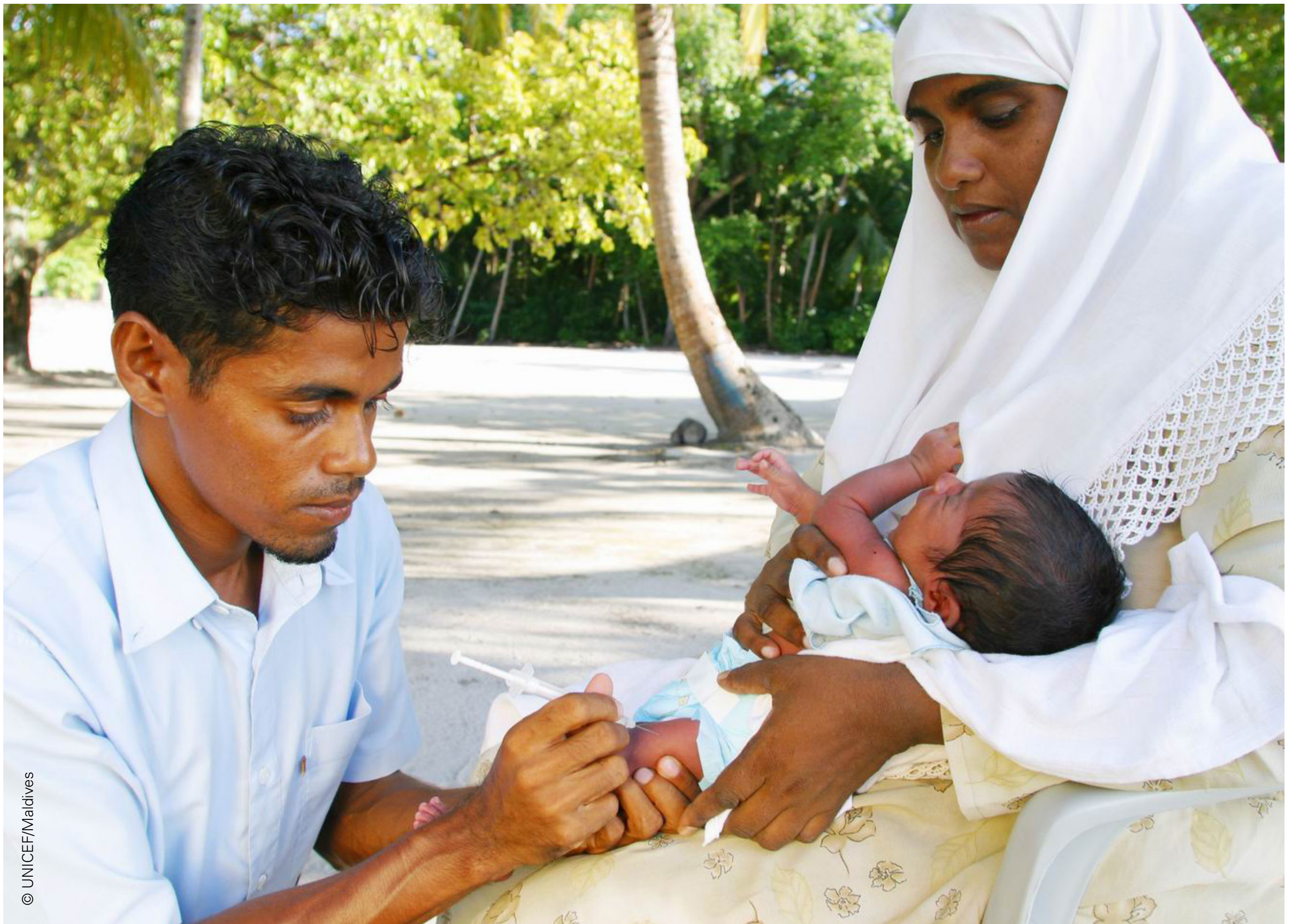
Acronyms

BCC	Behaviour Change Communication
CHW	Community Health Workers
CSC	Consortium for Street Children
CPD	Continuing Professional Development
CPR	Contraceptive Prevalence Rate
CPHC	Certificate in Primary Health Care
ENAP	Every Newborn Action Plan
FP	Family Planning
FHW	Family Health Worker
GBV	Gender-Based Violence
GE	Gender Equality
GoM	Government Maldives'
HMP	Health Master Plan
HPA	Health Protection Agency
IST	In-Service Training
MNH	Maternal and Newborn Health
MOGFSS	Ministry of Gender, Family and Social Services
MPHF	Maldives National Forum on Revitalizing Public Health
NCDs	Noncommunicable Diseases
PHC	Primary Health Care
PHCWs	Primary Health Care Workers
PHU	Public Health Unit
QI	Quality Improvement
RMNCAH	Reproductive Maternal, Newborn, Child and Adolescent Health
RUCs	Regional Urban Centres
SAP	Strategic Action Plan
SOP	Scope of Practice
SRH	Sexual and Reproductive Health
SDG	Sustainable Development Goal
UHC	Universal Health Coverage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Introduction and background

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

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

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

Astana Declaration 2018

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

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

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

Evaluation of Community Health Worker programmes in the South Asia region

- Formative evaluation in seven countries – Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan and Sri Lanka
- Objectives
  - 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
- Desk review and key informant interviews at the national level in seven countries
- Analysis frameworks
  - WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programs, 2018
  - WHO health systems building blocks
  - Operational framework for Primary health Care by WHO and UNICEF
  - WHO gender responsiveness assessment scale

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

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Maldives - country context

Maldives has made significant socioeconomic progress over recent decades. Poverty has shown a consistent reduction and the country's overall Human Development ranking increased significantly.

The Government Maldives'(GoM) investment in health reflect its high-level commitment to achieving Universal Health Coverage (UHC) and the SDGs. Maldives has made notable progress in achieving health outcomes, including increased life expectancy, and a decline in maternal, newborn and child mortality. The Contraceptive Prevalence Rate (CPR) in Maldives is low. While the country has achieved high rates of immunization coverage, childhood malnutrition is still a problem in Maldives. The country has also achieved success in the control of communicable diseases. New health challenges are emerging including growing rates of Noncommunicable Diseases (NCDs).

Maldives has been able to largely provide UHC to its population. The public health system is the main health service provider in Maldives, with facilities stratified into primary, secondary and tertiary levels of care (Figure 1). However, Maldives continues to be heavily reliant on expatriate health professionals, and assuring the quality of services delivered continues to be challenging. Although the government is committed to providing PHC services for all its citizens including preventive care, government's policy has tended to focus on curative and hospital-based care.

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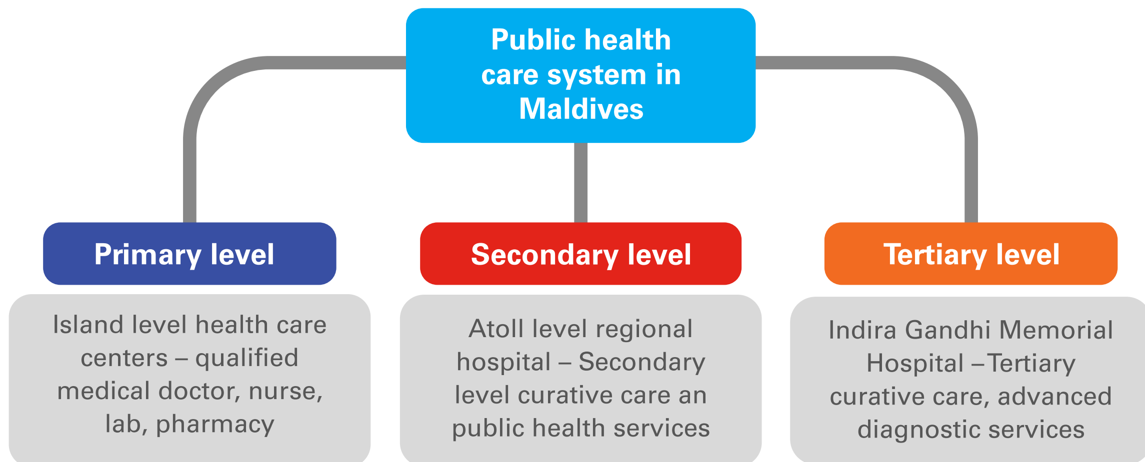

Figure 1: Public health care system in Maldives

The country is also vulnerable to the impact of climate change, and associated health threats, including the spread and re-emergence of vector-borne diseases.

Community Health Worker programmes in Maldives

There are two cadres of CHWs in the country- the Family Health Worker (FHW, or Family Health Officer) and the Community Health Worker (CHW, or Community Health officer). There are three different grades of CHOs, namely, Assistant CHO, CHO and Senior CHO. Both the CHW and FHW cadres are formal salaried government staff, employed by the MoH and fully integrated into civil service structures. CHWs are based in the Public Health Unit of the atoll hospital or island level Health Centre and provide a range of public health, preventive and curative services, including reproductive health services. Family Health Workers (FHWs), originally community-based, are now attached to the Health Centre, but continue to conduct home visits and outreach activities.

A profile of these CHWs is presented below.

	CHW/CHO	FHW/FHO
Total number (2019)	224	241
Gender	Both men and women (54% women, however, 2/3 of senior CHOs are men)	Majority (83%) women
Sector located in	Completely in the public sector	Completely in the public sector
Place of location	Facility	Facility
Payment structure	Salaried staff paid by government	Salaried staff paid by government

Health policy and system support for Community Health Worker programmes

The Government of Maldives (GoM) is committed to improving the quality of care in Maldives through the provision of quality, equitable and affordable service delivery to all citizens. Towards this, several policies and strategies are currently in place.

- **The GoM's Strategic Action Plan (SAP) (2019-2023)** is the central policy framework and planning document, aligned with the SDGs, that guides the overall development direction of the Maldives. Key health polices and strategies proposed in the SAP include a key focus on primary healthcare (PHC), and strengthening safe motherhood and child health and nutrition programmes.
- **The National Health Master Plan (HMP) 2016-2025** focuses on governance, public health protection and health service delivery. It outlines the strategic direction for the health sector with three specific outcomes: (i) building trust in the national health system; (ii) reducing disease and disability among the population; and (iii) reducing inequities in access to health-care services and medicines.
- **The National Reproductive Health (RH) Strategy 2014–2018** aims to ensure quality RH service provision that is affordable, equitable, and encompasses the principles of PHC. The **National RH Program** coordinates the implementation of the RH strategy and has developed standards, guidelines and protocols for HCPs providing Maternal and Newborn Health (MNH) care and Sexual and Reproductive Health (SRH) and FP services in health facilities at all levels. **The National Family Planning (FP) guideline** is non discriminatory and facilitates easy access to services. **National Standards for Adolescent and Youth Friendly Health Services** are also available. A new integrated RMNCAH strategy has been finalized and endorsed at policy level.
- **The MoH National Child Health Strategy (2016-2020)** is modelled on the Every Newborn Action Plan (ENAP) which emphasizes the delivery of packages of highly effective interventions along the continuum of care, new RMNCHA strategy builds on this, and looks at child health from a life course approach..
- **The 2018 Maldives Healthcare Quality Standards** provides a framework for all stakeholders to coordinate, plan, implement, monitor and evaluate quality improvement (QI) initiatives in health.
- **The Multisectoral Action Plan for the Prevention and Control of NCDs in Maldives (2016–2020),** focuses on preventive and promotive health interventions to bring about lifestyle changes and reduce health risks of the population.
- Under the **Aasandha social health insurance scheme**, introduced in 2012, rural populations have access to free public health care, with free referrals to the nearest hospital, including sea transport in emergencies, as well as treatment abroad for services not available in the country.

- Revitalizing community health workers to play an enhanced role as part of the PHC team in case finding, prevention and promotion.
- Building the capacity of CHWs to promote healthy lifestyle and provide health education.
- Establishing a mechanism for CHWs to regularly visit homes for health check-ups and awareness.

GoM's Strategic Action Plan

- Delivery of PHC in all inhabited islands
- Establishing a system of contact with families to create opportunities to educate and empower families for healthy practices
- Training and retention of a professional and ethical health workforce.

National Health Master Plan

- The **Maldives National Forum on Revitalizing Public Health (MPHF)** for policy makers, senior government, partners and other key stakeholders has been set up to promote high level dialogue on the need for, and the potential impact of investing in public health for national development. In addition, the MPHF facilitated dialogue on the strategic pathways for the integration of public health services, both primary and preventive health care and the creation of a continuum of care from promotive and preventive to curative and rehabilitative services.

- The GoM's SAP, the HMP, **the National Health Workforce Strategic Plan 2014–2018** and the 2018 Maldives Healthcare Quality Standards set out polices and strategies to address health workforce challenges and to build and retain a competent, professional health service workforce for the delivery of services and meaningful Quality of Care.

- **The Gender Equality (GE) Act,** enacted in 2016, prohibits discrimination on the basis of gender and promotes gender equality in all aspects of public and family life. In addition, the **Sexual Offences Act** provides for the protection of children and adults from all forms of sexual violence and includes an aspect to prevent rape within marriage. The Ministry of Gender, Family and Social Services (MOGFSS) collaborates with the MoH mainly in the development of the health sector's response to gender-based violence (GBV), as well as on areas such as SRH, FP, mental health and disability.

The **Ministry of Health** is responsible for formulating overall health policies and plans as well as regulating, monitoring and evaluating health service delivery. The **Health Protection Agency (HPA)** is responsible for regulating public health provision and protection and monitoring of public health services at all levels. The **Maldives Allied Health Council** registers, licences and regulates 73 different allied health professionals, including community health professionals, such as specialised community health cadres, and the PHCW, CHW and FHW cadres.

Transitions in governance

The health system has undergone major changes in recent years as a result of transitions in the governance and political context, including the decentralisation of the public healthcare delivery system and dissolution of the single coordinated system into six separate systems in 2010 and 2011. While the Health Protection Act of December 2012 restored the single system, it is acknowledged that these changes in government and health policy resulted in stressors and shocks to the health system, with a loss of institutional memory and destruction and disruption of processes. Further reforms, especially in relation to the decentralisation of the health

Scope of Practice (SOP) for CHWs and Primary Health Care Workers (PHCWs)

Community health professionals who deliver primary health care services and play an important role in increasing access to health services

- Patient assessment
- Clinical investigation and diagnosis
- Treatment
- Public health and education
- Immunisation and growth monitoring
- Reproductive health clinics
- Dispensing medicines
- Case and records management

Maldives Allied Health Council, 2019

sector, and the reorganisation of health care provision have been proposed by the current administration, including enhancing the role of dedicated community health workers. The SAP strategy is to establish Regional Urban Centres (RUCs) to organise the delivery of a comprehensive package of services and to reach all population groups in that zone (comprising 2-3 Atolls).

Roles and responsibilities of Community Health Workers

The functions and activities of the CHWs are documented and set out in the Scope of Practice (SOP) for CHWs and Primary Health Care Workers (PHCWs), recently developed by the Maldives Allied Health Council.

The FHW cadre was introduced when no other health care providers available on the islands to ensure the provision of services in these communities. They received 6 months training and were mostly from the community they worked in. While the FHWs are registered by the Allied, there was no SOP available for this cadre. They are attached to the island health centre where they report on a daily basis and continue to provide community-based services focused mainly on Family Planning. This cadre is being phased out, with none produced for over 10 years.

- **RMNCAH focus:** In most cases, women seek Maternal, Newborn and Child Health (MNCH) services, including ANC and PNC, from the doctor available in the island health centre or hospital, and increasingly, prefer to seek obstetric and gynaecological care in the Atoll hospital or in Male. CHWs and FHWs are no longer involved in deliveries, and their RMNCAH remit is mostly limited to conducting reproductive health clinics in the facility. They are still expected to undertake ANC and PNC visits as per a defined schedule, and provide clinical services when there is no doctor or nurse available. Few people reportedly go to the health system to receive any care related to sexual health or family planning.

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- **National programmes:** CHWs support the implementation of up to fifteen national public health programs coordinated by the HPA, including NCD screening and health education, communicable diseases preventive and promotive activities, reproductive health and family planning, nutrition program including growth monitoring and immunisation, prevention and surveillance activities for diarrhoea, and vector surveillance and control.

- **Community and home-based care:** CHW are now almost exclusively based in the Public Health Unit of the Health Centre or hospital, and rarely visit homes, with FHWs mostly conducting home visits. The overall perception was that community and home-based care were no longer valued.

- **Adolescent and Youth Friendly Health Services (AYFS):** CHWs and FHWs face challenges engaging young people. CHWs have their own personal beliefs and social norms which may impact on their effectiveness in providing SRH services, especially to adolescent health. The culture of silence on sex and sexual health in the country also influences the CHWs' behaviour and response.

- **Gender Based Violence:** Violence against women and girls continues to be widespread and threatens women's empowerment in the Maldives. While the MoH is providing mandatory training on GBV for the health workforce, reportedly the implementation of the health sector GBV guidelines is not optimal. Limited awareness among HCPs about the prevalence of GBV and language barriers with expatriate HCPs impact effective screening and response. CHWs often do not report instances of GBV as they perceive such issues to be not within their scope of work or they are family issues.

- **Mental Health:** CHWs were insufficiently trained to provide information and support to persons with mental health condition.

- **Administrative functions:** Many CHWs have a significant management and administrative role within the facility and may sometime be facility-in-charge.

- **Data collection:** CHWs and FHWs also play a key role in data collection and reporting. They compile these data and produce and submit regular reports to the atoll and HPA, as per agreed schedules. These cadres collect data manually, and compile and share these with the Atoll capital, who then consolidates it and sends the Atoll report to all 13-15 public health programmes, every month. There is no functional HMIS system yet.

- **Urban based CHWs:** Urban based CHWs focus mainly on NCDs and home visits for bedridden patients. Urban health centres provide a basic package of services and were reportedly not utilised for any RMNCH care.

Several factors were found to affect the effectiveness of CHWs.

- **Changing roles of CHWs:** It was felt that while CHWs and FHWs were knowledgeable and skilled, they were not utilising these skills optimally in the provision of care and guidance to families and communities. The guidance provided by these cadres is sometimes at odds with changing demographics and demands, with clients often by-passing CHWs to seek advice from doctors or do their own research on the internet. Their role has become more facility-based, administrative and managerial. These changes, especially in relation to RMNCH, were attributed to a number of factors including the availability of doctors and nurses on the islands, greater demand for and accessibility of specialist and higher levels care, increasing institutional deliveries. The policy of deploying doctors to every island was cited as one of the main reasons for these changes, contributing demotivation. The overall neglect of preventive services was seen as another contributing factor.

- **Lack of protocols and guidelines and/or application of protocols:** CHWs can be unclear about the content to be covered in their services and the quality standards to be met because of the lack of protocols. Even where protocols exist, staff may not be familiar with them and/or not apply them well ,for example, growth monitoring.

- **Lack of support to CHWs:** Staff shortages and capacity gaps within the MoH also affect the support and supervision CHWs receive to undertake their roles and responsibilities. For example, there are severe capacity gaps within the MoH health promotion unit that is responsible for providing training for CHWs on community mobilization, behaviour change communication (BCC) and other types of health promotion and it is no longer functioning. For the last six years, the positions have remained vacant in the section. The budget allocated is also minimal. As a result there is no focused health promotion agenda driven by the HPA, with awareness activities conducted in silos by respective programmes.

- **Workload pressures:** This was partly attributed to overall health workforce shortages across the country, as well as among the CHW cadre. Inequitable distribution of CHWs and responsibility for too many health programmes were also reasons for this. As a result of these pressures, CHWs had less time to undertake home visits and provide MCH related health education. CHWs and FHWs were increasingly being utilised in the island hospitals to shore up staffing levels and to enable these facilities to provide 24/7 care, leaving them with less time for home-based care.

- **Age and social norms:** More senior CHWs and FHWs were still valued and very well respected by the community. Younger CHWs, who have less acceptability amongst the community, often have difficulties raising issues of reproductive health, gender, and mental health, especially with older men. FHWs and CHW's own internalized gender norms may influence the extent to which they involve men in family planning and RH.

- **Gender:** Most communities accepted male and female CHWs, and there were few religious or gender barriers to women working as CHWs. However, because of the nature of small communities and CHWs' own gender norms, clients were often not sure of confidentiality when disclosing sensitive SRH related information and therefore may not seek care.

- **Poor teamwork:** There was a high turnover of expatriate doctors. When doctors leave, CHWs take on that burden, but their contribution is often not recognised, causing resentment and division among the team.

- **Poor recognition:** The limited recognition of their profession and the overall lack of Government support and investment in public health and preventive services hampered the effectiveness of CHWs. The work of these cadres was not well recognised or valued by the MoH and managers; their focus was on the doctors and curative care and this contributed to CHWs' demotivation.

Selection, education and certification

Figure 2: Selection and training pathways of Community Health Workers

Several challenges and barriers were highlighted in the enrolment for training and the training itself.

- **Lack of clarity on roles and responsibilities:** The FHS needs greater clarity about the roles and responsibilities of these CHW cadres produced through the PHC training course, as well as what is expected of them from the MoH. This information will ensure that the graduates produces have appropriate and relevant skills and competencies for the job, meeting the needs of the health sector and the population.

- **Need for practical training:** It was felt that CHWs were not fully competent and needed more practical skills to provide comprehensive family support.

- **Declining interest in PHC course:** Enrolment and interest in the PHC course has been declining in recent years. The enrolment and production of CHWs is not aligned to MOH staffing needs or requirements and there is limited communication between the institution and the MoH to agree short- or long-term production targets. Limited job opportunities, a lack of clarity about CHW roles and responsibilities on the ground, uncertainty about their role and position within the PHC team, prohibitive cost of higher education, poor remuneration for CHW cadres, and the low status and lack of recognition of the value of public health and PHC professions were all cited as reasons for the declining interest and enrolment in the PHC course.

- **Gender barriers:** In the past, the majority of student enrolled in the PHC courses were men, mainly because there used to be a lot of travel involved in the job, but in recent years more women are applying for the course.

- **Resource constraints for in-service training:** There were limited resources available to meet the high operational costs of reaching such a widely distributed and dispersed health workforce. The usual training delivery approach was cascade training with atoll level master trainers trained centrally in Male, who then trained other health workers at the atoll and island levels, including the CHW cadres. However, this was very expensive. Increasingly, more affordable and cost-effective approaches are being explored and adopted, such as facilitating training at the atoll or island level for all health workers, as well as providing training remotely.

- **Lack of systematic in-service training:** In-service training was delivered on an ad hoc and opportunistic basis with limited systems and processes in place to assess training needs or to evaluate the quality, effectiveness and impact of such training. There was also shortage and high turnover of technical staff at the HPA and other levels to conduct such training.

Management and supervision of Community Health Workers

Deployment

On completion of training, CHWs can return to their original post or apply for a vacant post elsewhere as advertised by the atolls or across the MoH. There is less flexibility now as a result of the Civil Service rules and regulations regarding employment and remuneration, such as facility-based staffing norms. These rules no longer allow the atolls to manage the distribution of the workforce as per their needs.

Remuneration and allowances

CHW salaries are low, resulting in the low motivation of CHWs, and challenges in attracting, deploying and retaining CHWs, especially in the more remote islands. When CHWs update their knowledge, they often go back to their original posts without a promotion or salary increment, because there are no higher-grade jobs available. There is also disparity between the remuneration of public health and CHW cadres and that of the curative health professions, and this is a major cause of CHW dissatisfaction.

Career progression

The lack of a career pathway and career advancement opportunities were factors linked to low motivation, lack of job satisfaction and attrition among the CHW cadre. While Civil Service Commission data recognises 3 CHW grades, including ACHO, CHO and SCHO, there are few approved SCHO posts available. Even if one does succeed in getting promoted to SCHO, while it attracts a salary increment, there is no job enrichment, and little or no difference between the responsibilities of the ACHO and those of a Senior CHO.

Due to prevailing gender related barriers, although the majority of PHC graduates are female, it is mostly men who are in the senior positions.

The CSC was working with the MoH and Allied Health Council to develop a professional and technical structure for the CHW cadres and a new salary structure.

Supervision

There were no CHW supervisory posts identified and there are no arrangements in place for training CHW supervisors or mechanisms for the provision of supportive supervision for CHWs. Insufficient funding, shortages and turnover of technical and supervisory staff, and geographical barriers were some of the factors hampering the provision of regular supervision and monitoring. The limited financing for public health and the operational costs of reaching the widely dispersed

health workforce make quality supervision challenging. The main link for CHWs is with the HPA, who are responsible for supervising the programmatic aspects of their work, but due to staffing shortages in the HPA, it was difficult for the technical staff to undertake the required monitoring trips.

Supportive supervision from the atoll level to island level health facility is also weak and infrequent, with the majority not providing this type of supervision at all. The reasons for such poor supervision practices were attributed to demotivated senior staff, lack of professionalism and poor attitudes towards the job. This lack of quality supportive supervision impacts on quality serve provision and contributes to weak compliance with national guidelines and accountability.

Integration into the health system

While the CHW cadres are employed by the government and their training is publicly funded, public health and preventive services were perceived to be neglected. The PHC team was also felt to lack teamwork. CHWs worked alone, and were both physically and professionally separated from the curative health team.

Data collection

Data collection, management and reporting, which are still largely manual, paper-based systems, are key responsibilities of the CHWs and FHWs. CHWs and FHWs record information gathered through the home visits on standard forms and submit these to the public health unit (PHU) at the atoll level, where the data are are entered. on to spreadsheets- there is no functional electronic information system, however DHIS-II is being piloted and will be gradually rolled over the coming years. Although CHWs have computers in the facility, these are not yet connected to the online system to enable them to enter and generate data. The roll out of DHIS2 is expected to harmonise the collection and analysis of data at facility level and create a more comprehensive information system with indicators for all health programs, including RMNCAH.

Community integration and engagement

In the past CHWs and FHWs had good relationships with families and the community. However, with the medicalisation of service delivery and the neglect of preventive/promotive services, many CHWs and FHWs have lost their status and the trust and confidence of the community. With the CHW cadres now largely facility-based, their interactions and engagement with the community through household and school visits were now minimal. Many CHWs and FHWs were no longer linked into community structures and groups, such as the mothers' groups. Community Social Groups are being established to address the needs of vulnerable and marginalise individuals and their families and CHWs could play a key role in this.

Availability of appropriate medicines and supplies

Drugs, equipment, and supplies are generally available – without stockouts – except in some islands where they experience outages of contraceptives and other supplies.

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

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

Policy area	WHO recommendation	Fulfilment	Remarks
Selection	Specify minimum educational levels	Green	
	Require community membership and acceptance	Red	No community involvement in selection of CHW/FHW
	Consider personal capacities and skills	Red	Not considered
	Apply appropriate gender equity to context	Red	Not considered
Pre-service training duration	Based on scope of work, roles and responsibilities	Yellow	Some aspects not covered, eg. Family support
	Consider competencies required	Green	
	Consider pre-existing knowledge and skills	Green	
	Social economic and geographic circumstances of trainees	Red	Not considered
	Institutional capacity to provide training	Green	
	Expected conditions of practice	Yellow	Not considered

Competencies in pre-service training curriculum	Include core competencies domains-preventive & promotive, diagnostic, integration with wider health system, interpersonal skills, social determinants of health, personal safety		
	Include additional competency domains- treatment and care services - if required		
Training Modalities	Balance theory and practice		Practical training inadequate
	Use face-to-face and e-learning		
	Conduct training in or near the community		
	Consider interprofessional training approaches where relevant		
Competency based certification	Use competency based formal certification for CHWs who have successfully completed pre-service training		
Supportive supervision	Establish appropriate supervisor – CHW ratios		No identified supervisory cadre
	Train supervisors		
	Coach and mentor CHWs		
	Use of observation of service delivery, performance data and community feedback		
	Prioritise improving quality of supervision		Not prioritized
Remuneration	Remunerate practising CHW with a financial package commensurate with job demands, complexity, number of hours, training and roles		Remunerated, but low
Contracting Agreements	For paid CHWs provide written agreements specifying roles, responsibilities, working conditions, remuneration and workers' rights.		
Career Ladder	Offer career ladder to practising CHWs		Available, but very few posts
	Further education and career development linked to selection criteria, duration and contents of pre-service education, duration of service and performance review		No career pathway even after further education
Target population size	Expected workload		No defined population
	Frequency of contacts		
	Local geography		Not considered
	Nature and time requirements of the services provided		
Collection and use of data	CHWs document the services they provide		
	CHWs collect, collate and use health data on routine activities		
	Train CHWs and provide feedback on performance based on data		Training provided, but inadequate
	Minimize reporting burden, harmonize requirements		Not harmonized
Type of CHWs	Adopt service delivery models comprising CHWs with general tasks as part of integrated primary health care teams		CHWs part of PHC team, but roles unclear
	CHWs with more selective/specific tasks to play a complementary role based on population health needs, cultural context and workforce configuration		
Community Engagement	Involve communities in selecting & monitoring CHWs & in priority setting of CHW activities		No community involvement
	Support to community-based structures		
	Engage relevant community representatives in decision making, planning, budgeting & problem-solving		
Mobilization of Community Resources	CHWs to identify priority health and social problems and action plans		
	Community needs and develop required responses		
	CHWs mobilise and coordinate local resources		
	CHWs to facilitate community participation and links to health facilities.		
Availability of supplies	Ensure CHWs have adequate and quality-assured commodities and consumables through the integration in overall health supply chain;		Frequent stockouts
	Adequate reporting, supervision, management, training, and mHealth to support supply chain functions		

Private sector contribution to Community Health Worker programs

The private sector plays little or no role in CHW programs. With the exception of one institute- Villa College – which provides a the private sector is not involved and make no financial or technical contribution to the education, training or employment of CHWs in the Maldives.

Financing and resource mobilisation

The major source of health funding is from the government and much of the financing has targeted curative and hospital-based care. Underfunding of public health and preventive services has impacted on PHC workforce strengthening, including attracting and retaining public health workers and CHWs at PHC level.

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

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

Policy support measures

- **Public Health Revitalisation:** While the Maldives has not articulated any specific post Astana commitments, the **revitalisation of public health and promotive and preventive services** is a national imperative, emphasised in the GoM SAP and at the 2019 Maldives Public Health Forum (MPHF). Government policies and the political leadership need to redress long-standing underinvestment in public health and preventive services and the medicalisation of care, all of which had adversely impacted on the effective and efficient delivery of PHC and community-based care.

- **Integrated PHC Services:** It is expected that the revitalisation process will provide the opportunity to **reorient the services and provide a continuum of care,** and that there will be renewed focus on a community health approach. **Integrated PHC services** and strengthened referral and back referral systems between primary, secondary and tertiary levels of care will be a key focus. At the PHC level, roles and responsibilities and scopes of practice across all PHC cadres should be clearly defined, supported by appropriate job descriptions, guidelines, and work processes.

- **Decentralisation:** Any effort at decentralisation, as being debated in parliament, must learn from the lessons of previous experiences and every effort should be made to **mitigate any further shocks or disruptions to health systems and the health workforce.**

- **Leadership and Governance:** The **coordination and collaboration of stakeholders** with different interests, agendas, priorities and operational modalities across the public and private sector will be essential to achieve the Astana vision for PHC, the GoM SAP and the MPHF commitments. **Robust leadership and management capabilities within the Ministry of Health** will be required to drive the GoM SAP agenda for health, lead large-scale reforms, health system strengthening, including building a competent PHC workforce, and ensuring equitable and quality integrated services at PHC level. Shortages and high turnover of HPA technical staff needs to be addressed to provide this leadership and to realise the government's ambitions. **Sufficient financing and human resources** should then be committed to ensure technical staff, managers and health workers with the necessary skills and competencies are in place to implement and monitor the programs and achieve the expected outcomes. Technical support from external partners provided in a coherent and responsive manner will also be useful towards this.

- **Financing:** Increased financing and **adequate funding allocations for cost effective public health and preventive services,** including CHW programs are needed. There were concerns about the sustainability of the Aasandha health insurance scheme and a coherent and efficient model was needed urgently for **sustainable health protection system** in the country. The establishment of a **Public Health Fund** to emphasize the importance of disease prevention over disease control and treatment, create public health awareness, broaden public health activities and build a public health conscious society would be valuable.

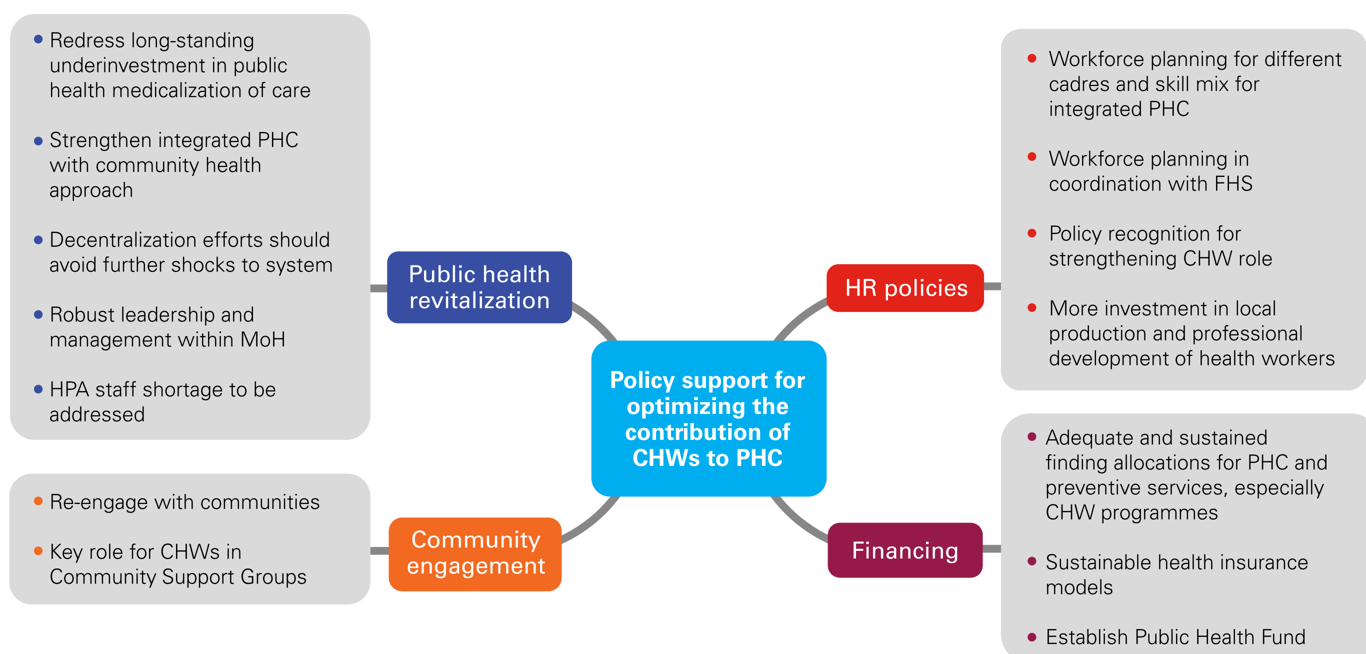
- **Community Engagement:** Community engagement, education and empowerment are necessary conditions for reversing the over-medicalisation of health, for changing mindsets and unhealthy behaviours, and to enhance the take up PHC and preventive services. The PHC team, including CHWs need to be supported and enabled **to re-engage with and empower the community.** Multisectoral Community Social Groups are being established to address the needs of vulnerable groups and CHWs and FHWs are well placed to play a key role in these Groups.

- **Health Workforce Policies: Robust and evidence-based workforce policy and plans,**

aligned with national policies and strategies are needed. Workforce planning should go beyond profession-specific planning and consider the different cadres and skill mix required to deliver comprehensive and integrated PHC services. Such health workforce planning should be **undertaken in collaboration with the FHS,** so that this institution can ensure its production and supply of CHW meets the demand, as well as the competencies and skills mix required. There should be recognition at the policy level that the role of the CHWs needs to be **strengthened and optimised,** and this should be reflected in their remuneration, accountability framework, overall support system and an enabling environment. The country's high dependency on an expatriate health workforce jeopardizes the sustainability and continuity of health services and **more investment is needed in local production and professional development of health workers.**

- **Addressing gender:** The gendered dimensions of these issues should be recognized and 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 well addressed.

Figure 3: Policy support measures for Community Health Worker programmes



System support improvements to optimise Community Health Worker cadres

Optimising Community Health Worker roles and responsibilities

Optimising CHWs and FHWs role and responsibilities would be a key strategy in addressing the current health workforce shortages, especially as the CHWs are a multiskilled cadre, and can perform the clinical functions of a nurse, doctor or pharmacist, as well as undertake public health functions.

- **Revised roles and responsibilities:** The scope, and the roles and responsibilities of both the CHW and the FHW, should be revisited to ensure that these were still appropriate and feasible given the changing disease burden, proposed revitalisation and reforms, and the new technical and job structures under development within the CSC. Clarifying and coordinating functions of all facility and community-based providers would improve and enhance teamwork and integrated service delivery approaches. Any revision of the job descriptions should be informed by an assessment of the capacity of the current FHWs and CHWs, including their utilisation and functionality, and an identification of training needs.

- **RMNCAH roles and responsibilities:** CHWs no longer have a role in deliveries, but they should continue to provide facility and home-based ANC and PNC services. For issues of SRH, women and girls do not want to go to the doctor and there is an unmet need in this area which CHWs can fulfil.

- **Adolescent and youth friendly health services:** CHWs and FHWs are well placed to support teachers and school counsellors with the delivery of the

SRH components of the school health program. Expanding the overall coverage of quality AYFHS will require strengthening the capacity of all PHC health workers on AYFHS, including the FHWs and CHWs, through pre-and in-service training.

- **ECD and Nurturing Care:** CHWs also play a critical role in providing nurturing care, early childhood development and nutrition services through existing platforms. The nurturing care framework has been globally adopted by UN agencies and the World Bank as an essential framework with a package of services.

- **Mental health services:** CHWs' role in improving the availability, access and take up of mental health services for all population groups at all levels needs to be strengthened.

- **Gender based violence:** Information on sexuality, GBV and the power dynamics in gender relations is not well covered in the PHC training course. The role of the CHWs cadres in the prevention of SGBV and the support of survivors could be enhanced with further training and support.

- **Utilisation and expanded role of CHWs:** The intermediary treatment provided by many of the doctors currently deployed to the islands could as well be provided by trained CHWs. It was suggested that it would be more effective and efficient to have a well-staffed and functioning hospital on every Atoll, and on the smaller islands, CHWs, who are from the community and understand the context, could competently cater for the needs of this population without the support of a doctor. CHWs have taken on administrative and managerial roles and responsibilities, and should instead reassume their public health roles.

> Develop health service capacity and mechanisms to support national efforts to address gender-based violence.
> **GoM's Strategic Action Plan**

Pre-service education, in-service training and Continuous Professional Development

- **Strengthening pre-service training:** The current curriculum needs to be more responsive and aligned with current needs. The duration and variety of clinical and practical training needs to be expanded.

- **Addressing gender and SGBV:** Sexual and gender-based violence (SGBV), its health consequences and appropriate responses should also be integrated into the PHC curriculum and covered regularly through in-service training for CHWs, FHWs and other health workers, including expatriate staff, involved in the provision of RMNCAH services. Continuous and ongoing sensitisation and training should be provided for these cadres to ensure that they may themselves do not reinforce gender norms and perpetuate gender inequalities in their work because of their own gender norms.
- **Strengthening training capacity:** Faculty, mentors and supervisors should be exposed to regular and continuing professional development and have sufficient teaching and technical knowledge and skills to deliver the curriculum effectively.

- **Strengthening in-service training:** Strengthening the links between pre-service and in-service training will be critical for maintaining and updating CHWs competencies, as well as improving their performance and the quality of care provided. More robust and cost-effective mechanisms were required to provide quality in-service training (IST), mentoring and continuing professional development (CPD). Greater use of blended learning approaches, eLearning and smartphone apps could reduce costs and ensure more equity in the availability and accessibility of IST and CPD. Investing in building the capacity of a critical mass of atoll and island-based master trainers, supervisors and mentors is also critical. IST strategies and practices should also consider the gendered-specific needs and responsibilities of women and the participation of women in IST should be enabled and encouraged.

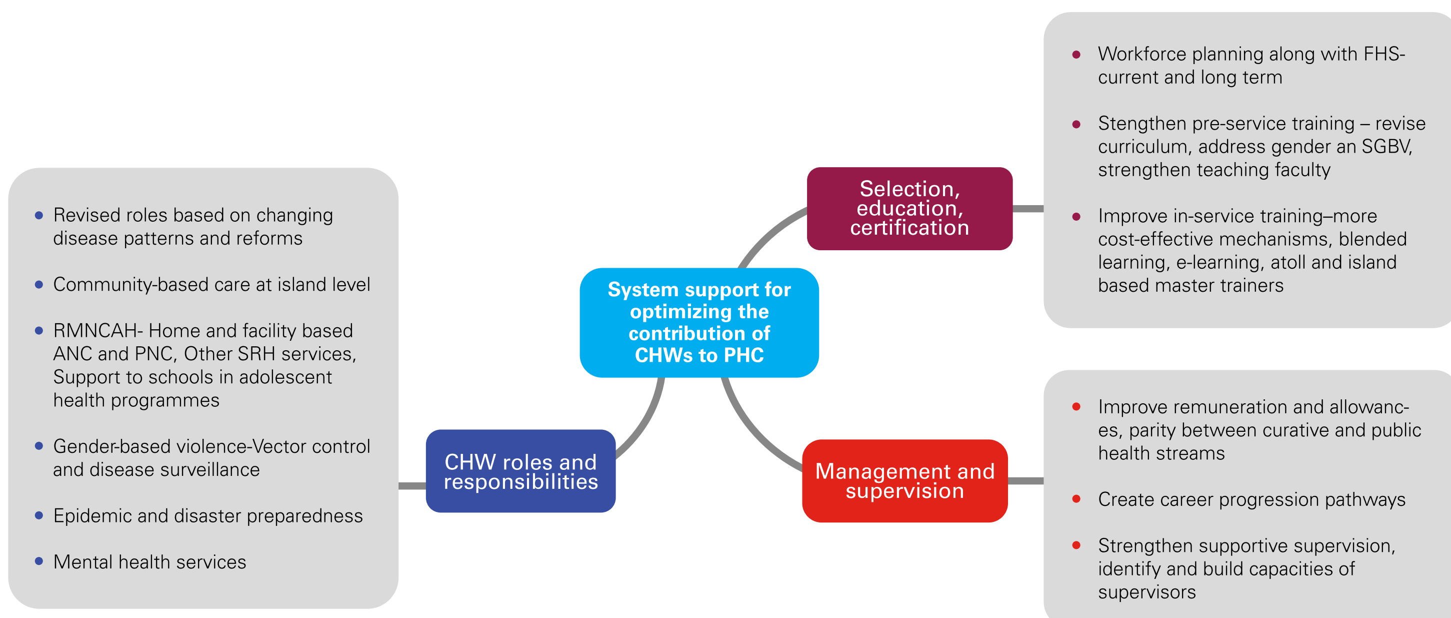
Management and supervision

- **Remuneration and allowances:** Greater efforts should be made to make CHW jobs and careers more attractive, in terms of the remuneration and incentives provided. The disparity between curative and public health and preventive health cadres should be reduced as this is a major cause of CHW dissatisfaction. The new job structure being developed by CSC reportedly has proposed a comprehensive compensation package, including salary, benefits and allowances.

- **Career progression:** The new professional and technical structure for the CHW cadre being developed by CSC in collaboration with the MoH and Allied Health Council at the time of this study, was expected to create multiple levels and grades from CHO to community health manager. The perceived to be a positive step in recognising this cadre, and in addressing some of the system support gaps identified, particularly in the areas of career advancement.

- **Addressing gender-specific needs:** The extent to which women's competing gendered responsibilities

Figure 4: System support measures for Community Health Worker programmes



and gendered-specific needs affect their employment needs and preferences, and their ability to take up CPD or opportunities to advance professionally in their careers should also be considered and monitored in the development and implementation of the new professional structure.

- **Supportive supervision:** It is vital that that adequate resources and financing are allocated for effective monitoring and supportive systems and processes. Increasing the availability and distribution of supervisors across atolls and islands, as well as strengthening their skills, competencies and attitudes is vital.

Making the Community Health Worker programme gender transformative

The 2016 Gender Equality Act promotes gender equality in all aspects of public and family life. The MoH needs to aim for more gender sensitive policies and practices to move towards a more gender transformative approach.

One of the barriers in making policies more gender responsive is the lack of financing and human resources to ensure the consistent application and implementation of the policies, as well as improving the understanding among ministries and the Island Councils of their shared roles and responsibilities in advancing gender equality. More robust inter-ministerial coordination in the implementation of the legal and regulatory frameworks and harmonised monitoring and data on the impact of the policies were also critical. While many CHWs and FHWs are from the community and understand the context, they require more sensitisation and training on gender norms in the community and how they influence access to health and health care. CHW cadres could play a greater role in promoting gender equality and the prevention of GBV. FHWs that were well embedded and accepted in the community also had a role in ensuring men and boys have access to the health and social services they need and to challenge and change harmful gender and social norms through working with men.

Conclusions

Changing demographics, socio-economic contexts, and epidemiological transition in the Maldives is affecting patterns of health care service utilization and the determinants of demand for health care services. Preserving the valued status of these CHWs in the community, and supporting, recognising and rewarding their performance and contribution through improved policy and system support will ensure they are available to continue to provide quality facility and community based public health care and prevention at the PHC level. The public health revitalisation process will provide opportunities to create such support mechanisms and build stronger and sustainable PHC systems and workforces.

Policy brief for Maldives

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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