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Policy brief for Nepal

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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Address: UNICEF Regional Office for South Asia (ROSA)
P.O. Box 5815, Lekhnath Marg, Kathmandu, Nepal
Tel: +977-1-4417082
Email: rosa@unicef.org
Website: www.unicef.org/rosa/

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Authors
Subha Sri Balakrishnan and Margaret Caffrey

Principal Investigator/Team Lead - Margaret Caffrey
Study Advisor - Matthews Mathai
Gender Advisor - Subha Sri Balakrishnan

Data synthesis
Subha Sri Balakrishnan and Margaret Caffrey

LSTM Desk review contributors
Margaret Caffrey
Tara Tancred
Simone Filiaci

LSTM Research Support Team
Matthews Mathai, Study Advisor
Fiona Dickinson
Barbara Madaj
Somla Gopalakrishna
Tara Tancred
Simone Filiaci

LSTM Programme and logistics support team
Clare Littlewood
Keri Murray

UNICEF Team
Luula Mariano
Sam Bickel
Paul Rutter
Barsha Pradhan

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Acronyms

ANM	Auxiliary Nurse Midwife
AHW	Auxiliary Health Worker
BHCS	Basic Healthcare Services
CHW	Community Health Worker
FCHV	Female Community Health Volunteers'
GAP	Global Action Plan
GESI	Gender Equity and Social Inclusion
FCHV	Female Community Health Volunteer
FBOs	Faith-Based Organisations
GDP	Gross Domestic Product
HP	Health Posts
HFOMCs	Health Facility Operation and Management Committees
LARC	Long Acting Reversible Contraceptive
MCHWs	Maternal and Child Health Workers
MDG	Millennium Development Goal
MNCH	Maternal, Newborn and Child Health
MGH	Mother Group for Health
MSS	Minimum Service Standards
NAHD	National Adolescent Health and Development
NCD	Non-Communicable Diseases
NGOs	Non-Governmental Organisations
NHSS	Nepal Health Sector Strategy
OOP	Out-Of-Pocket
ORC	Outreach Clinics
PHC	Primary Health Care
PHCC	Primary Health Care Centres
RMNCAH	Reproductive Maternal, Newborn, Child and Adolescent Health
SBA	Skilled Birth Attendants
SDG	Sustainable Development Goals
SMNH	Safe Motherhood and Newborn Health
SRH	Sexual and Reproductive Health
UHC	Universal Health Coverage
VHWs	Village Health Workers

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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 SDGs. 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
    - o To understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes
    - o to determine the key policy adjustments and interventions needed to address any gaps
    - o 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
    - o WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programs, 2018
    - o WHO health systems building blocks
    - o Operational framework for Primary health Care by WHO and UNICEF
    - o 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.

Nepal - country context

The constitution of Nepal guarantees basic health services for all citizens as a fundamental right. Nepal has embraced international commitments and continues to support interventions towards achieving the SDGs and Universal Health Coverage (UHC) and has made notable progress in improving the overall health outcomes of its citizens, achieving the Millennium Development Goal (MDG) 4 and almost achieving MDG 5.

Despite the steady progress in health outcomes, improvements are needed in the quality, coverage and take-up of services, especially for Maternal, Newborn and Child Health (MNCH) services. Access to and utilization of PNC services is a major challenge, which is further compounded by cultural practices where post-natal women are not touched until ritual purification on the 11th postnatal day. While there has been steady progress in the reduction of child and newborn mortality, newborn mortality comprises 52% of under-five mortality. Nepal has the third highest prevalence of child marriages, and seventeen percent of girls aged 15-19 years are already mothers or pregnant with their first child. Only 15% of currently married adolescents use a modern method of contraceptives.

While communicable diseases continue to pose problems, there is a growing prevalence and mortality from non-communicable diseases (NCDs). Nepal also faces many health challenges related to inequity and many citizens continue to face financial, socio-cultural, gender, geographical, and structural barriers in accessing health services. There is a wide gap in the rate of maternal, child and newborn mortality between different socio-economic groups by ethnicity, wealth, education, and geography.

The health service delivery system is mixed and made up of the public sector, non-governmental organisations (NGOs) and the private for-profit sector. Rural and underserved populations are served primarily by the Ministry of Health, while private providers tend to serve the urban populations. Rapid urbanization has led to a greater need for urban health services.

Nepal has made progress in terms of achieving a degree of gender parity within education, however patriarchy is pervasive within the country and widespread gender inequality is observed in multiple areas such as wealth, employment opportunities and education.

In the last five years, Nepal has seen fundamental changes in the national administrative, legal and political set up. The constitutional amendment of 2015 redefined the structure of the government in Nepal and the government has been divided into three tiers - local, provincial and federal. The 2015 Constitution provided these sub-national authorities with greater political, fiscal and administrative powers, concurrently with the federal government. This change to a federal governance system is expected to have several consequences for the health sector too.

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Community Health Worker programmes in Nepal

There are currently three key CHW cadres in Nepal who fall within the WHO CHW definition.

1. Auxiliary Nurse Midwife, (ANM) (previously known as the Maternal and Child Health Worker)
2. Auxiliary Health Worker (AHW) (previously known as the Village Health Worker)
3. Female Community Health Volunteer (FCHV)

A profile of these CHWs is presented below.

	ANM	AHW	FCHV
Total number	Not available	Not available	50,166 (2,019) One per 500 population
Gender	All women	Majority men	All women
Sector located in	Completely in the pu-blic sector	Completely in the public sector	Completely in the public sector
Place of location	Facility	Facility	Community
Payment structure	Salaried staff paid by government	Salaried staff paid by government	Volunteer

AHWs and ANMs are based mainly in the Health Post, the lowest level of health facility. Some Village Health Workers (VHWs) and Maternal and Child Health Workers (MCHWs) were automatically upgraded to the new ANM and AHW posts based on seniority, while others were promoted after completing prescribed national training courses. Where other cadres like staff nurse are not available at the Health Post, the AHW or ANM may take on the facility in-charge role. As well as their facility-based duties, the AHW and ANM cadres are also responsible for undertaking outreach clinics (ORC) in the community, working closely with the FCHVs. FCHVs are community-based.

The CHWs have varied roles and responsibilities as depicted below.

Goal of the FCHV program

"support the national goal on health through community involvement in public health activities. This includes imparting knowledge and skills for empowerment of women, increasing awareness on health-related issues and involvement of local institutions in promoting health care".

National FCHV Programme Strategy 2010

	ANM	AHW	FCHV
Type of services provided	Preventive, promotive, curative	Preventive, promotive, curative	Preventive, promotive, curative
Areas of health covered	• Primary care maternity services including ANC, assistance at childbirth and PNC • Sexual and reproductive health (SRH) care at the HP or through the PHC-ORCs. • Family planning including Long acting reversible contraceptive (LARC) services • Child health- clinical case management of childhood illnesses, immunisation • Nutrition including vitamin A campaigns • Health education	• Immunization • Management of newborn infections, especially diarrhoea and pneumonia • Basic first aid • Health promotion/ education activities • Community mapping exercises.	• Home visits • Health education at the monthly Mother Group for Health (MGH) meetings • Family planning including promotion and distribution of family planning commodities • MNCH services including home visits during pregnancy, intrapartum, and postpartum period • Curative services- treatment of acute respiratory infection and diarrhoea within the community and referral when required • Support to national campaigns

Health policy and system support for Community Health Worker programmes

The Government of Nepal (GoN) has expressed its commitment to the global campaign of expanding people's access to quality integrated primary health care (PHC) in line with the 2018 Astana Declaration. Several relevant and comprehensive policy frameworks and operational guidelines are in place for provision of PHC including RMNCAH, addressing inequities, and planning for health human resources. Some of these are detailed here.

- **Achieving SDGs and UHC:** The GoN supports the Global Action Plan (GAP) for Healthy Lives and Well-being and has developed its own **GAP Country Action Plan** to accelerate the health-related goals and targets of the SDGs, with particular focus on PHC and data management. **The National Health Policy of Nepal (2014)** focuses on improving access to equitable and quality services and on providing basic healthcare services (BHCS), which are free of charge. The focus of the **Nepal Health Sector Strategy (NHSS) 2015-20** is on achieving universal health coverage (UHC) across four strategic areas including equitable access, quality health services, health systems reform, and a multisectoral approach, and emphasises community based PHC for achieving UHC.

- **Addressing disease burden:** In response to the changing disease burden in the country, the health sector aims to strengthen the provision of **integrated preventive and promotive services at local level**, improve the coordination between local and higher-level health facilities to provide curative

services, prioritising communicable, maternal, neonatal and nutritional (CMNN) interventions to safeguard gains in reducing the burden of CMNN diseases.

- **Addressing RMNCAH needs:** The **Safe Motherhood and Reproductive Health Act (2018)** guarantees the reproductive rights of every woman, while the **2018 Public Health** Act focuses on integrated service provision for reproductive, child and maternal health. The Safe Motherhood and Newborn Health (SMNH) Programme Road Map of 2019 aspires to ensure healthy lives and promote the well-being for all mothers and newborns. **The 2006 National Policy on Skilled Birth Attendants (SBAs)** acknowledges the importance of SBAs at every birth. Currently, a midwifery cadre is being produced. **Abortion is legal** for any Nepali woman and is not dependent on age or marital status. Free abortion services are available in public facilities. **The National Family Planning Costed Implementation Plan 2015-2020** aims to improve access to rights-based FP services and reduce unmet need for contraceptives. In 2016, the government of Nepal endorsed the country's **Every Newborn Action Plan**. The 2000 **National Adolescent Health and Development (NAHD) Strategy** was developed with the aim of improving the health and socioeconomic status of adolescents and was revised in 2018.

- **Addressing inequities:** The Nepal health sector has a good track record in addressing exclusion related goals and the GoN has introduced a number of measures to reduce inequality in access to health care services in Nepal and address the constitutional right to health care. **The NHSS (2015-2020) has equitable access as one of its four principles**, with related disaggregated targets. The MoHP has developed a number of **Gender Equity and Social Inclusion (GESI) responsive policies, strategies, programmes and guidelines.**

- **Planning Health Human Resources:** The NHSS 2015-20 recognizes the importance of planning, developing, producing, and retaining skilled human resources. Currently the MoHP is developing an **HRH strategic plan/roadmap** and aligning it with the federal context to guide HR planning, management and development at all levels. The **2010 National Female Community Health Volunteer Programme Strategy** outlines implementation arrangements for the program.

Changes with the federal governance structure

The new federal governance arrangement brings with is several changes in health sector governance and several challenges have been envisaged during this process. Under the federal governance arrangements, the MoHP is responsible for overall health policy formulation and strategic planning at the federal level, and locally elected officials in the local government have the authority to make critical decision on policy, funding and programming and are responsible for the planning and delivery of health services. The complexities of the transition raise concerns about the risk of discontinuities and disruption to service delivery.

- Provincial and local governments will require a range of technical and managerial competencies and skills to deliver their health sector responsibilities, which is being addressed through various MoHP supported interventions, but it is expected to be a long-term investment.

- The Federal Government has developed Minimum Service Standards (MSS) for all levels of health facilities and hospitals which outline the minimum standards in terms of governance, health workforce management, finances, information and quality, clinical management and the management of support services that Federal, Provincial and Local Governments will be expected to meet and maintain.

- The implementation of the Employee Adjustment Act is currently underway and involves the redeployment of the health workforce across the three-tiers of government. This is seen as a major challenge to the delivery of PHC services. The availability of staff and skills mix at PHC level has been affected, with oversupply in some palikas and facilities, and undersupply in others, and some health workers have been mismatched to posts. The provision of both facility and community-based services delivery have been disrupted

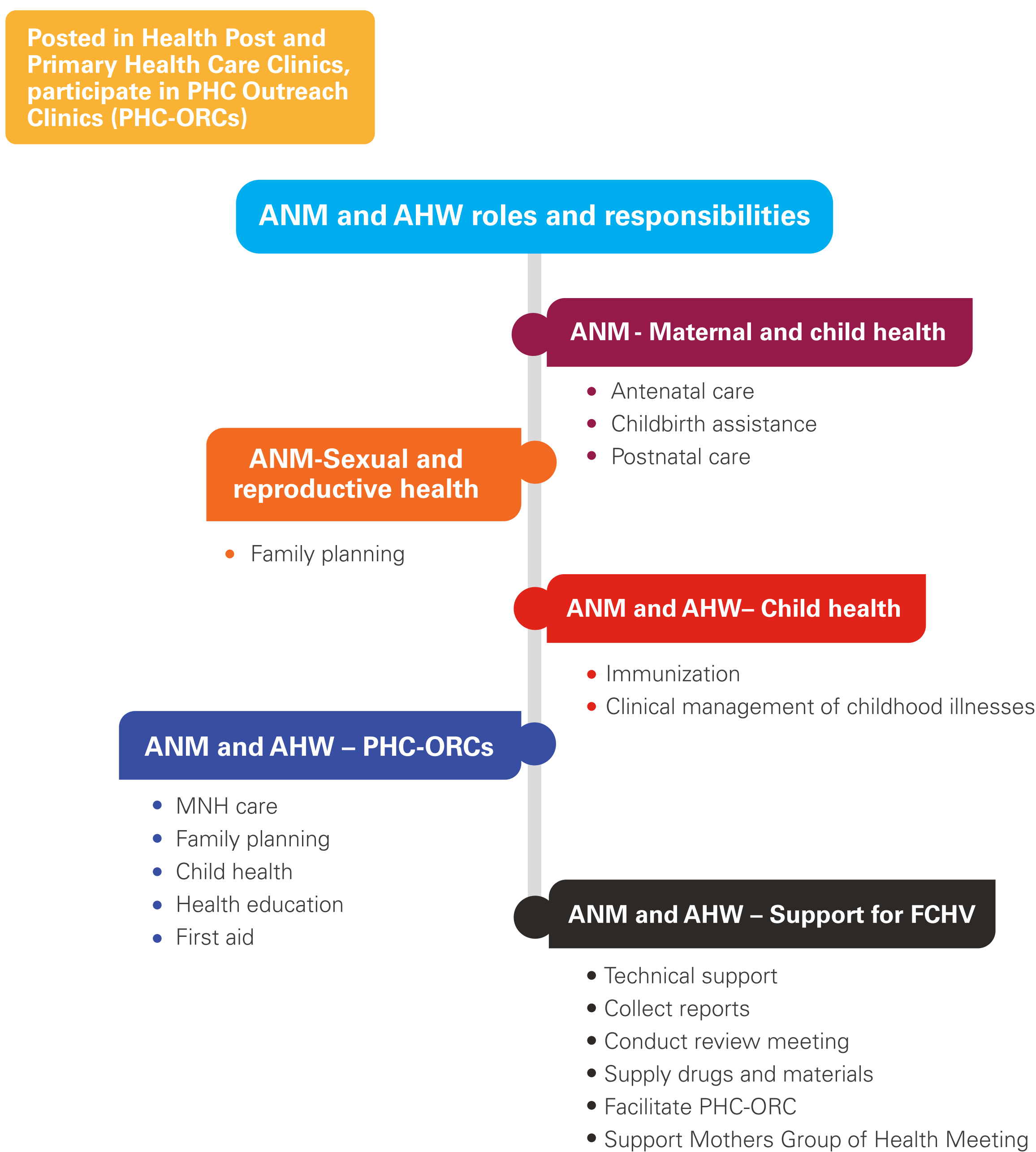
> Universal and equitable access to health services shall be ensured with priority to population of various age groups, gender, classes and regions.
>
> **National Health Policy 2019**

Roles and responsibilities of Community Health Workers

ANMs and AHWs are deployed in Primary Health Care Centres (PHCC) and in Health Posts (HP), which are the first institutional contact point for basic health services. They also conduct monthly community-based outreach clinics to bring health services closer to communities.

Their roles and responsibilities are depicted in Figure 1.

Figure 1: Auxiliary Nurse Midwife and Auxiliary Health Worker roles and responsibilities

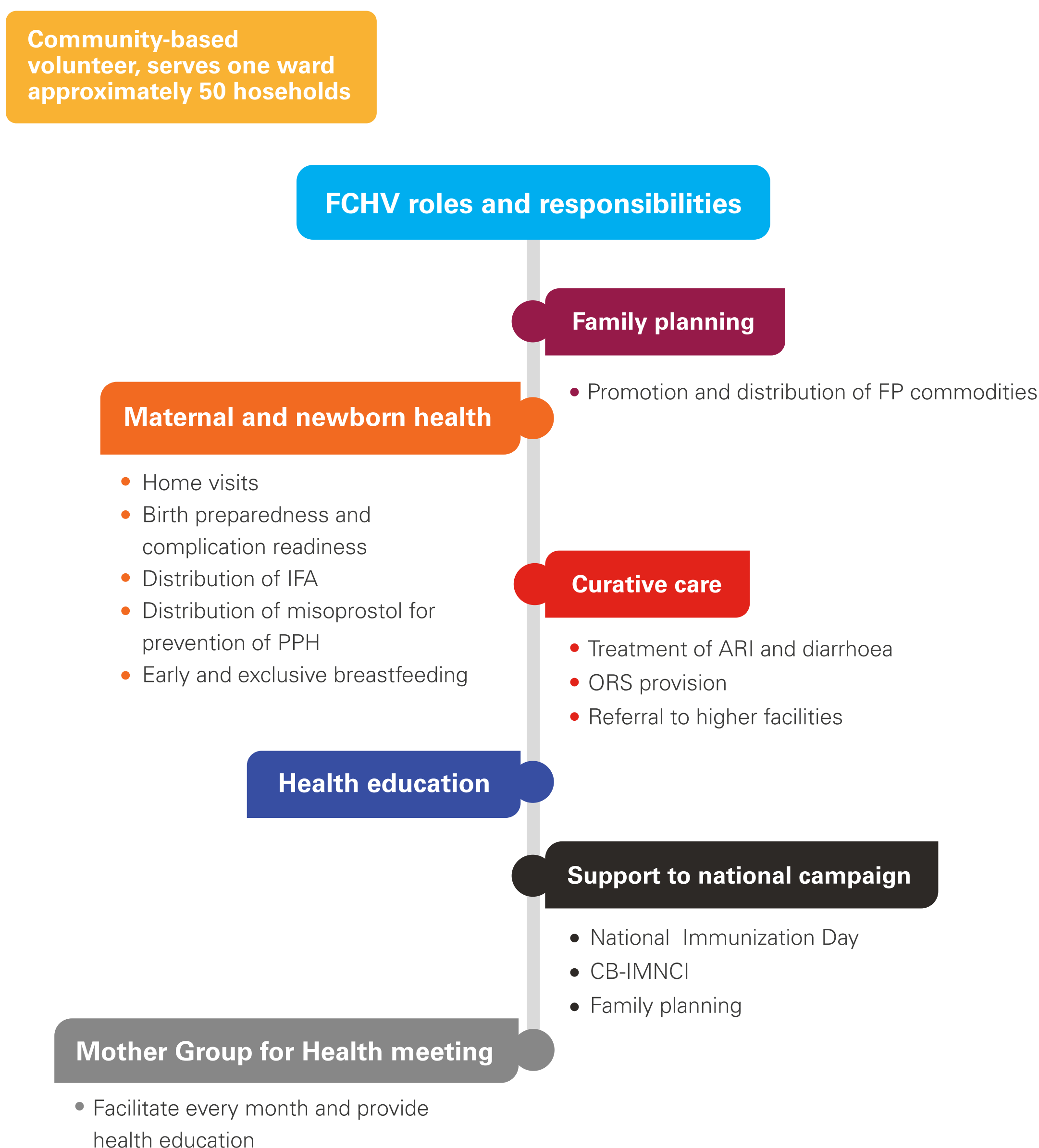


FCHVs have been active in Nepal since 1998. Their major role is to advocate healthy behaviour by mothers and community members, to promote safe motherhood, child health, and family planning, and other community-based health issues and service delivery. Their roles and responsibilities are shown in Figure 2. Their value and contributions are widely acknowledged.

FCHV programme continues to be the backbone for PHC in Nepal.
Safe Motherhood and Newborn Health

Road Map 2019

Figure 2: Roles and responsibilities of Female Community Health Volunteers'



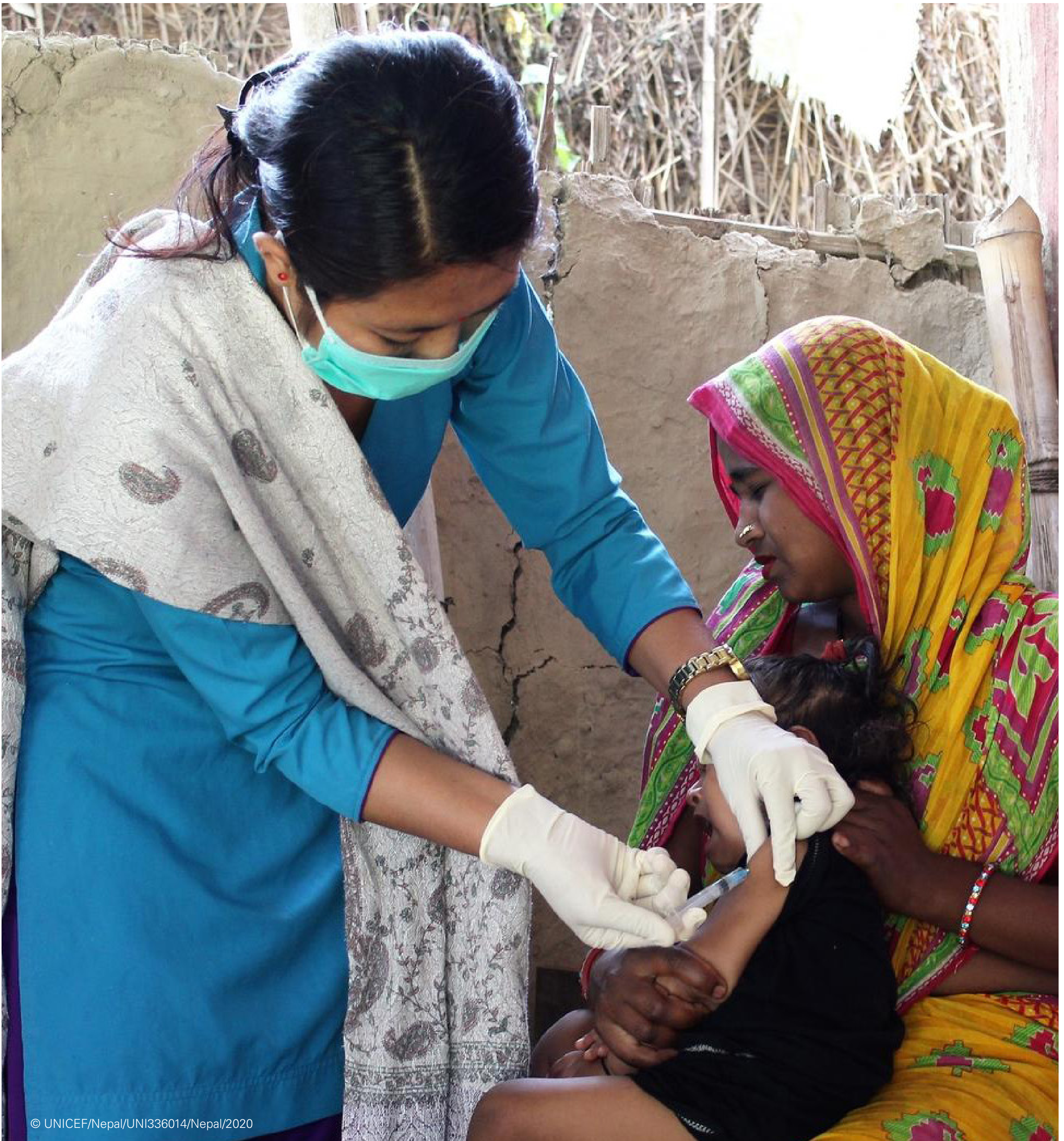
FCHVs are local to their communities and have an understanding of those they are providing services to, culturally, experientially and linguistically, which contributes to making health care more accessible and acceptable. They also receive gender training and share this information to the women in their communities who are then able to question cultural and social norms surrounding menstruation, pregnancy, parental behaviour and family. FCHVs themselves report a high level of satisfaction with their role and their retention rate is very high.

Several constraints affecting the effectiveness of CHWs were identified:

- **Health worker shortages** are a challenge at all levels, including at the PHC level and amongst the ANM and AHW cadres. Where more senior staff are not available in these facilities, the AHW or ANM have to take on the facility in-charge role in health facilities. This may constrain their work in the community and their involvement in the PHC-ORCs. In more remote facilities, ANM posts are vacant and the AHWs have to take responsibility for the provision of sexual and reproductive health services, which may not be acceptable to some communities. ANM shortages in birthing centres results in women being unable to give birth in these facilities. ANM and AHW shortages also impact the frequency and quality of the monitoring, support and supervision provided for FCHVs.

- **Cultural appropriateness:** ANMs and AHWs are often not local to the area and may lack contextual knowledge of the cultural and social norms and the local language, which may affect the quality and appropriateness of the care provided.

- **Competing priorities for FCHVs:** There is a decline in some services provided by the FCHVs in recent years. FCHVs effectiveness could be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affected by the multiple competing priorities, and demands being made on them from different donor agencies and programs.

- **Unable to reach the marginalized:** FCHVs may not be reaching and providing services to those women who most need their services - those who are excluded and vulnerable and have limited mobility, because of their gender, ethnicity, socio-economic status, caste and geographic location.

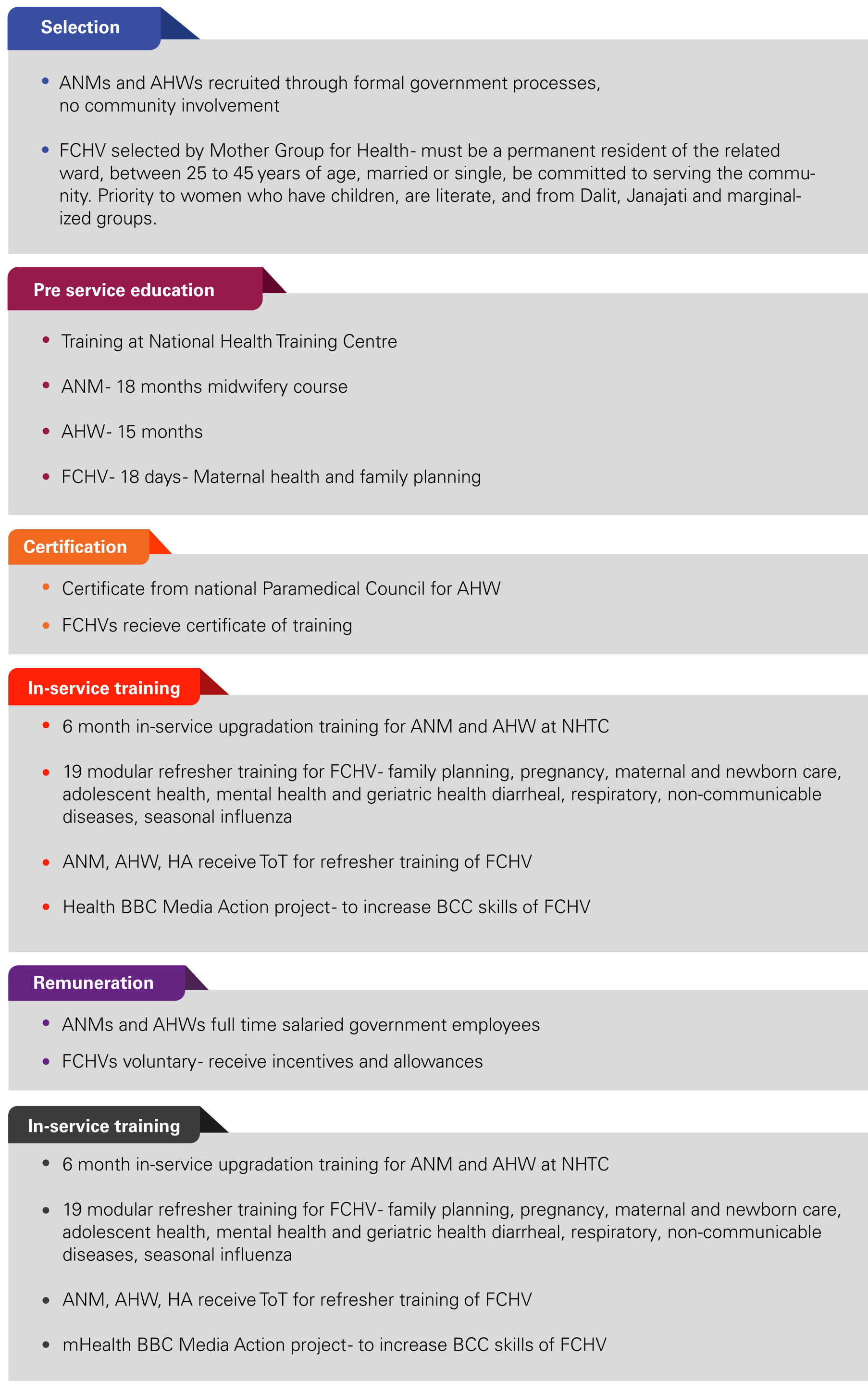
- **Gender and social norms:** Gender and social norms affect heath seeking behaviour and take up of RMNCH services and are key barriers to accessing Female Community Health Volunteers' (FCHV) services, especially among ethnic minority women in Nepal such as Dalits, Madhesi, Muslim, Chepang and Tamang.

- **Caste discrimination:** FCHVs from lower castes may face discrimination when making visits to other women in their communities.

- **Lack of coordination between divisions:** There are major challenges at the policy level regarding ownership and coordination, with duplications in the community activities between and within the programs of health divisions, creating vertical planning and management. FCHVs are often found to be overburdened because of this and duplication of tasks occurs.

Selection, education and certification

Figure 3: Selection and training pathways of different Community Health Workers



Challenges and barriers to effective training of CHWs include:

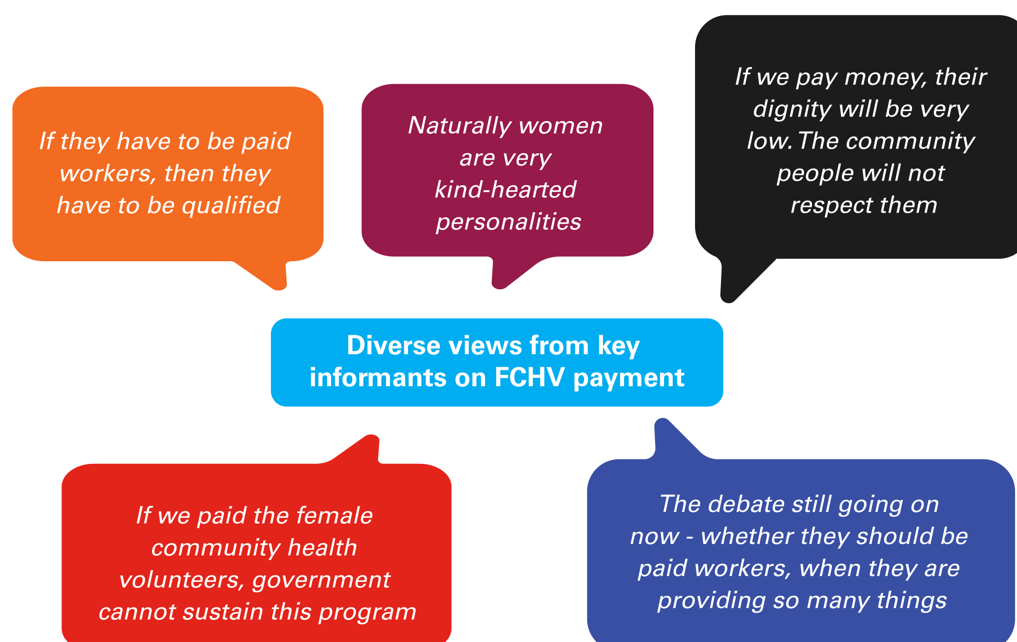
- **Quality of pre-service education:** This was perceived to be poor with a heavy focus on theory rather than practical skills. This led to a lack of confidence in providing services at PHC level.
- **Lack of training follow-up:** There is rarely evaluation of training provided post the training.
- **Poor literacy levels of FCHVs:** The literacy levels of some FCHVs and the quality of the training they receive impacted on their ability to communicate important health messages, particularly those related to medicine.
- **Need for gender-related training:** The 2018 GESI Strategy of the Health Sector proposes incorporating GESI and gender-based violence education within health-related academic courses and training curricula.

Management and supervision

Career progression and remuneration

While ANMs and AHWs are fully salaried government employees, compensation of FCHVs has been a controversial element of the program with many justifications for continuing the voluntary nature of FCHVs.

Figure 4



However, in the absences of formal remuneration FCHVs split their attention and time between competing aid agencies, which could be affecting their performance and the quality of the services they provide. Nepal's health system relies heavily on its unpaid FCHVs and this appears to reinforce gender disparities. However, respondents did not seem to perceive this as a gender issue. The possibility remains that women are being exploited and are unable to gain economic independence.

Supervision

FCHVs are supervised and managed by the in-charge in the local health facility, which could be a HA, staff nurse, AHW or ANM. In addition, the Mother Group for Health, a community group, is also expected to have a role in monitoring and evaluating the work of the FCHV and reporting back to the local health institution. However, FCHVs in remote areas face challenges with the monitoring and supervision they receive. Further, while the supervision for the FCHV is expected to take place in the community, most supervision occurred at the health facility.

ANMs and AHWs are supervised and managed by more senior ANMs and AHWs, as well as more senior staff in the health facility. The quality and standard of supervision and mentoring was weak, due mainly to the lack of supervisors and clinical mentors. SBA trained ANMs were not receiving adequate supervision, mentoring and on-site coaching to ensure they had the required skills and competencies and the support to confidently perform safe deliveries. There were also concerns that supervision and mentoring could further deteriorate as responsibility for these functions are devolved under the federal governance structures.

Integration into and support by the health system

FCHVs and other staff based at the facility are expected to work collaboratively. FCHVs refer clients to the staff in the facility, mobilise community members to utilise facility-based health services, and support AHWs and ANMs to conduct the PHC-ORCs. Health Post staff also facilitate the monthly review meetings for FCHVs, provide them with refresher training, supervise them, and provide funding for MGH meetings.

However, the deployment of AHWs and ANMs was not planned systematically, skewing equitable distribution. This situation has been exacerbated by the ongoing employee adjustment process, with many unfilled posts in the more remote, less attractive postings. Frequent transfers of the AHW and ANM cadres also disrupted services.

Community integration and engagement

FCHVs have a close relationship with the community, formalized in the form of the MGH. The local health facilities, local government and the local MGH are involved in the selection and monitoring of FCHVs. Members of the MGH and other CSO support the FCHVs in their work. FCHVs were perceived to be a unifying force within the community.

There were some challenges with community engagement too.

- **Addressing men:** Because of prevalent gender norms, FCHVs find it difficult to have conversations on topics such as sexual health with male members of their communities.

- **Reaching ethnic minority groups:** Despite being selected from within the community by the MGH, a considerable number of ethnic minorities are not accessing or taking up the services provided by the FCHV. A lack of trust in volunteers and perceived indignities experienced when using health centres were some of the key barriers to accessing FCHVs' services among ethnic minority women in Nepal such as Dalits, Madhesi, Muslim, Chepang and Tamang.

Availability of medicines and supplies

Availability of supplies is a challenge for all cadres and this impacts their ability to perform agreed tasks and achieve the expected results. There were concerns that under the new federal arrangements that sub-national governments would have the authority to do their own procurement, which may not be efficient or effective.

> "The community health volunteer is making the community unite. Because they are bringing the women on a monthly basis in a home, and they sit together, they discuss, and I have seen that even though we are not paying anything to the FCHV, the FCHV is providing tea to the mothers group"
>
> **Key informant interview, MoHP**

Health information systems

FCHVs are responsible for maintaining monitoring checklists, including supply stocks, register reviews, service coverage, and referral activities, and mothers' group attendance. They record vital statistics like births and deaths and collect data on approximately 30–40 indicators that feed into the national HMIS. Because many FCHVs have limited schooling the reporting is mainly pictorial. Each FCHV is expected to submit data and a report of her activities on a monthly basis to their AHW or ANM supervisor, who then compile these to input into the HMIS.

However, online reporting from all health facilities was weak, with completeness, quality and timeliness a problem In addition, more needs to be done to ensure that data generated is used to inform evidence-based decision making, especially at Palika and facility level. FCHVs are required to complete a large amount of reporting and recording and due to limited numeracy and literacy skills, they often struggle when recording data.

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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 Nepal 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 the recommendation not fulfilled)

Policy area	WHO recommendation	Fulfilment	Remarks
Selection	Specify minimum educational levels	Green	
	Require community membership and acceptance	Yellow	No community involvement in selection of ANM/AHW. Community (MGH) selects FCHV.
	Consider personal capacities and skills	Yellow	Not considered for ANM/AHW. Key criterion for selecting FCHV.
	Apply appropriate gender equity to context	Yellow	Not considered for AHWs, but considered for ANMs and FCHVs.
Pre-service training duration	Based on scope of work, roles and responsibilities	Green	
	Consider competencies required	Green	
	Consider pre-existing knowledge and skills	Green	
	Social economic and geographic circumstances of trainees	Yellow	Not considered for ANM/AHW. Considered for FCHV
	Institutional capacity to provide training	Yellow	Inadequate institutional capacity in terms of faculty, curriculum, practical training
	Expected conditions of practice	Green	
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	Green	
	Include additional competency domains- treatment and care services- if required	Green	
Training Modalities	Balance theory and practice	Yellow	Practical training inadequate
	Use face-to-face and e-learning	Green	
	Conduct training in or near the community	Red	Training at NHTC
	Consider interprofessional training approaches where relevant	Yellow	Midwifery faculty not available
Competency based certification	Use competency based formal certification for CHWs who have successfully completed pre-service training	Green	
Supportive supervision	Establish appropriate supervisor – CHW ratios	Yellow	Shortage of supervisory cadres
	Train supervisors	Red	No special training for supervisors
	Coach and mentor CHWs	Yellow	Supervision not always supportive
	Use of observation of service delivery, performance data and community feedback	Yellow	Supervision usually in facility, not in the community
	Prioritise improving quality of supervision	Red	Not prioritized

Policy area	WHO recommendation	Fulfilment	Remarks
Remuneration	Remunerate practising CHW with a financial package commensurate with job demands, complexity, number of hours, training and roles		ANMs and AHWs remunerated, but FCHV voluntary
Contracting Agreements	For paid CHWs provide written agreements specifying roles, responsibilities, working conditions, remuneration and workers' rights.		Not available
Career Ladder	Offer career ladder to practising CHWs		Available for ANMs and AHWs, but not for FCHV
	Further education and career development linked to selection criteria, duration and contents of pre-service education, duration of service and performance review		ANM and AHW promoted on seniority basis.
Target population size	Expected workload		No defined population for ANM and AHW, defined for FCHV
	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		High burden, literacy skills of FCHV limiting factor
Type of CHWs	Adopt service delivery models comprising CHWs with general tasks as part of integrated primary health care teams		
	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		
	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 involvement in Community Health Worker programmes

Health services in Nepal are also provided by private for-profit sector, non-governmental organisations (NGOs) and faith-based organisations (FBOs) and are mainly focused on serving urban populations. There was no evidence of private for-profit sector involvement in the training or employment of these CHWs cadres.

Financing for Community Health Worker programmes

According to the 2015-2020 Health Sector Strategy, Nepal's government will seek to fund the provision of Basic Health Services entirely from government revenues, however, should there be the need, it may also resort to utilizing resources from external development partners. Since 2004, a sector-wide approach has been adopted in the health sector with most EDPs directing their support through the government's budget.

While there has been an increase in government spending on health as a share of gross domestic product (GDP), external funding for health has been decreasing in relative terms in the recent years. Out-of-pocket (OOP) expenditure remains high at 60.4%.

The government has begun the decentralisation of planning and budgeting to the local level with the allocation of a budget comprising an unconditional equalization grant that can be used for administrative and developmental activities including for the health sector, and a conditional grant earmarked for specific sectors, mainly education, health, and agriculture sectors. The following concerns were expressed about challenges in the financing mechanisms under the federal structure.

- Local governments would deprioritize health in favour of funding activities whose benefits are more tangible and visible to their constituents.
- There are disparities across Palikas in terms of resource mobilization at local level, and service provision may be compromised in the more resourced constrained local governments.
- Scarce resources at Palika level would be used on hospital infrastructure, with little regard for the resources needed to operationalize and staff these hospitals.
- The cost of the FCHV program, which includes basic training, refresher training, training materials, and incentives is shared between the government and donor agencies. There are concerns about the CHW programme being overlooked in the transition to federalism; there have reportedly been occasions when local governments had overlooked budget allocation for the FCHV program.

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

The transition to federalism provides opportunities for Nepal to improve the quality of its health systems; however such policy reforms will require unwavering political commitment and structural innovations.

- **Stakeholder alignment:** The involvement of health and non-health stakeholders at all levels, advocating for a "health in all policies" and strengthening multi-sectoral mechanisms will enhance stakeholder ownership and buy-in to the ongoing federal transition.

- **Community engagement and empowerment:** A key intervention in the Nepal GAP Country Action Plan is enhancing the capacity of community members to participate in health care governance, management and service delivery, as a means of enhancing quality. In order to have a meaningful impact, community engagement will require a deep understanding of the intersecting experiences of marginalisation and exclusion of those most affected. Harnessing the potential of CHWs such as the FCHV cadre will enhance such engagement as well as improve the coverage, reach, quality and equity of PHC programs.

- **Governance and leadership capacity at all levels:** Robust governance and leadership systems and capacity at all levels will be critical for the successful transition to Federalism and to enhance cooperation across federal, provincial and local governments. Structures and staffing should be expanded and strengthened at local levels to ensure there is sufficient capacity to coordinate and manage the implementation of multiple programs.

Collaboration and partnerships among governmental, non-governmental and private sectors shall be promoted, managed and regulated in the health sector, and private, internal and external investments in health education, services and research shall be encouraged and protected.

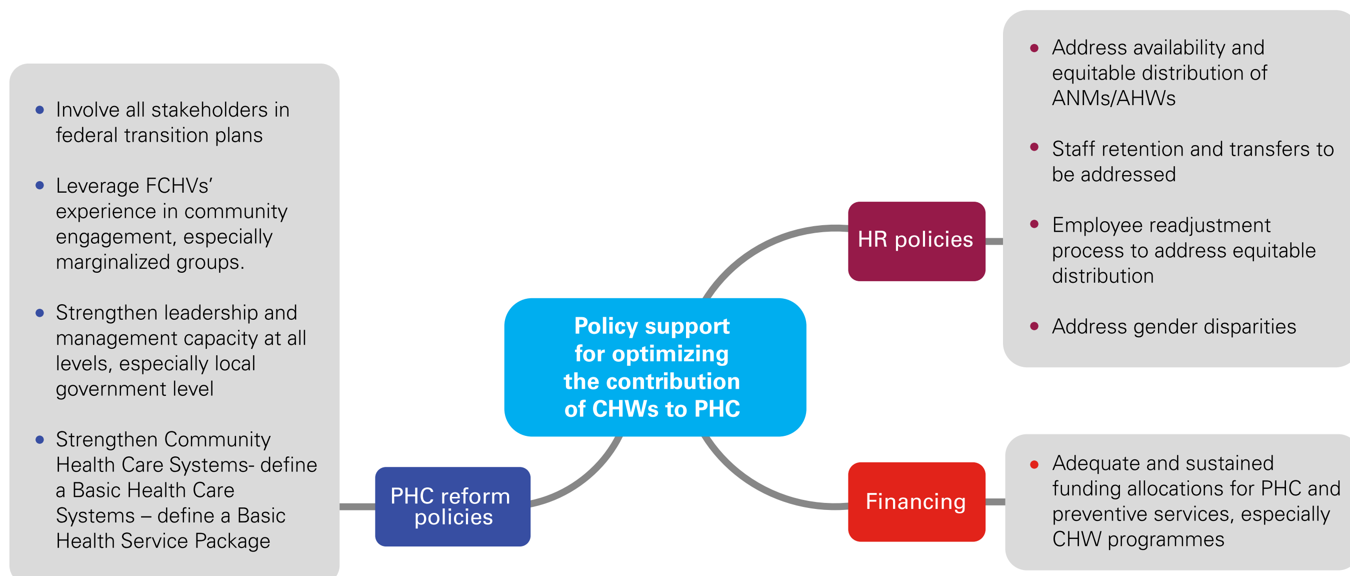
National Health Policy 2019

- **Health Financing:** Sustained investment in PHC and CHW programs and increased financing for health overall, but particularly, adequate funding allocations for promotive and preventive services, including CHW programs is critical.

- **Strengthening community health policy frameworks:** Defining and implementing a basic health package which prioritizes community health and especially health promotion, alongside a focus on communicable and non-communicable diseases is needed.

- **Health human resources:** The current health structures and health workforce struggle to provide adequate health service delivery in a context of increasing populations, changing burden of disease, advances in health technologies and the political transition. A key strategic area should be the strengthening of the frontline and community health workforce, including addressing the availability of ANMs and AHWs. Health workforce policies and plans also need to provide guidance for staff retention, including appropriate incentives and the management of transfers. Concluding the Employee Readjustment process and ensuring that staff are matched to the right post and are deployed where they are most needed, ensuring remote and underserved areas are staffed, will be key. Health workforce polices should ensure that gender disparities in the remuneration, planning, recruitment, deployment, retention and motivation of these cadres and the overall PHC workforce are addressed.

Figure 5: Policy support measures for optimizing the Community Health Worker programme



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System support improvements to optimise Community Health Worker cadres

Optimising Community Health Worker roles and responsibilities: Reviewing the role of the Female Community Health Volunteers'

Since the FCHV was introduced in 1988, the health landscape has changed dramatically, AHWs and ANMs have been trained up to work in the communities, and there are many questions surrounding the future of this cadre. While there is general satisfaction with this cadre, there is ongoing policy discourse and debate as to whether the FCHV role and a volunteer CHW cadre are still relevant and appropriate given the socio-demographic changes in the country, and the government's commitment to professionalisation of the RMNCH health workforce.

It was felt by key informants that with the transition to a federal state service and increasing education levels, users might have higher expectations of the care they receive. One view was that the FCHV cadre should now be phased out and be replaced with salaried and adequately trained and more competent CHWs, who would be more accountable for the work they perform. However, such policy reforms need to be underpinned by the evidence and lessons learned from the implementation of the FCHV program.

FCHVs are also overburdened with multiple roles beyond what was originally envisaged. The current roles and responsibilities of the FCHVs should be revisited to determine an appropriate package of services, considering the context, the needs of the population, the availability and skills set of the FCHV, among others.

The SMNH Road Map recommends that the FCHV programme should be further strengthened especially in areas with low care seeking behaviour and among those with poor knowledge of complications. More culturally sensitive interventions, like home-based care, are needed to promote access to and the use of postnatal services and to reduce maternal deaths during the post-natal period, especially in geographically challenging areas. Ensuring FCHVs have accurate knowledge and appropriate BCC skills to communicate this information effectively in a context specific manner will be vital.

Strengthening Community Health Worker education and training

There is need for strengthening the training of both FCHVs and ANMs. Coordinated and coherent approaches to quality in-service training, supportive supervision, mentoring and on-site mentoring are needed to reduce fragmentation and help reinforce CHWs initial education and training through a continuum of learning.

Remuneration and allowances

A few key informants suggested that the remuneration of the FCHV should be increased or formalized while some felt that the package of incentives and allowances were sufficient compensation. The government does not have the financial means to transform the FCHV role into a salaried position. There were no links made between the performance, satisfaction and retention of FCHVs, and the lack of remuneration.

Supervision

Mechanisms should be put in place to monitor and hold ANMs and FCHVs accountable for the quality of their services they provide and to enable continuous learning and improvement. While being integrated into the formal PHC system, these cadres need to be simultaneously embedded in and supported by the community in order to sustain their community connectedness and acceptability. With the relevant orientation and training, HFOMCs could play a greater role in monitoring and overseeing health care provider performance, as well as encouraging the provision of quality and respectful care. Closer collaboration and interaction of ANMs and AHWs with FCHVs, the MHGs, community leaders as well as conducting outreach to marginalized groups may help to build relations on both sides.

Reaching the unreached

There has been limited success reaching marginalized groups, such as the Dalit, Janajati, Madhesi and Muslim groups. There is need to strengthen CHW programmes and to work in collaboration with local government and local communities to develop appropriate strategies and interventions to expand coverage and ensure access to services of unreached and marginalised populations.

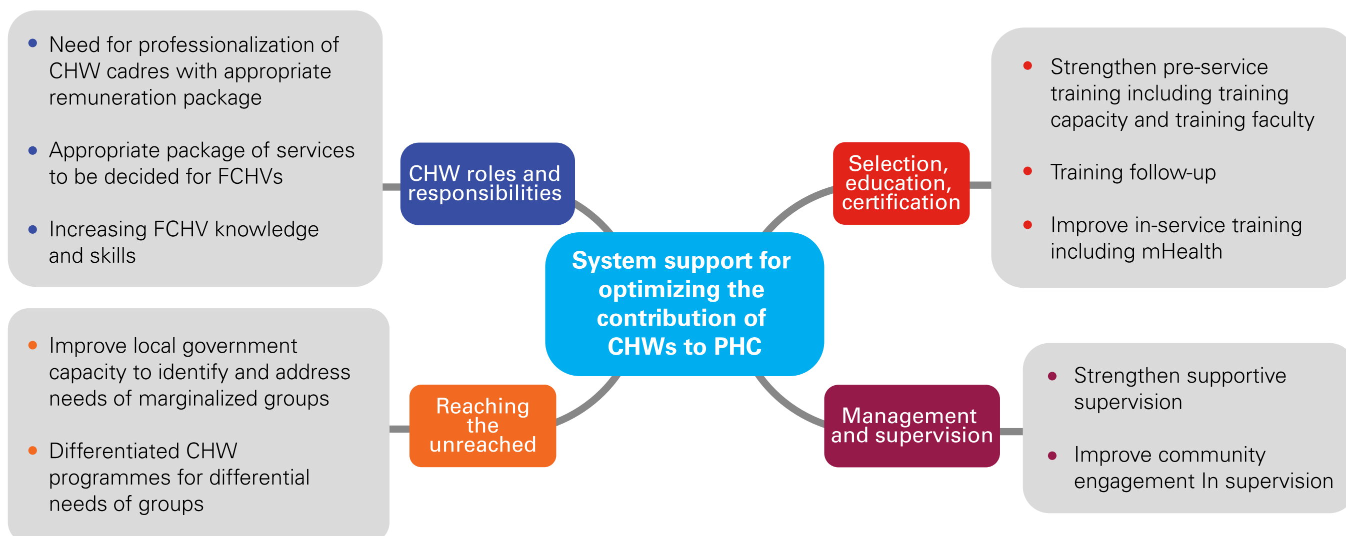
Local governments, working in partnership with PHC health care providers, FCHVs, local leaders, MGH, representatives of marginalized groups, and Health Facility Operation and Management Committees (HFOMCs) should endeavour to gain a deep understanding the needs of the different population groups in the area, and to use such information to plan and invest in differentiated and targeted PHC facility, outreach and community based programmes that meet the unique information and healthcare needs of these populations, especially marginalised groups.

Levels of accessibility, cultural norms and health needs vary considerably across and between urban, and rural locations and across the remote mountainous, hilly and terai areas of the country, and differentiated CHW programs which can address the specific needs of the various population groups in the different geographical areas could be explored.

Community Health Workers roles in emergency preparedness

In the face of emerging pandemics like COVID, not only have CHWs a key role to play in health education and helping to reduce the population's susceptibility to infection, with the trusting and established relationships they have established with the community they are well positioned to explain and help implement and monitor preventive measures in managing current and future public health crises and outbreaks.

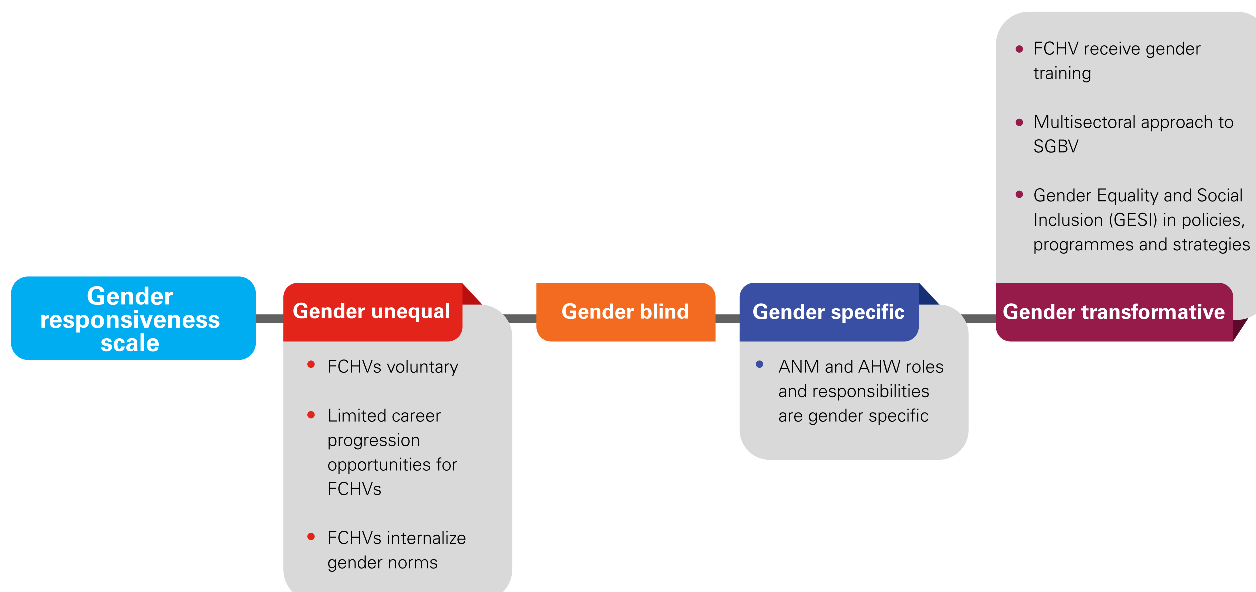
Figure 6: System support for optimizing Community Health Worker programmes



Making the Community Health Worker programmes gender transformative

While many RMNCAH related policies and some aspects of the CHW program are gender specific and gender sensitive, very few policies and implementation frameworks have an explicitly gender transformative aim. The figure below depicts some aspects of the CHW programme in Nepal along the WHO gender responsiveness scale.

Figure 7: Gender assessment of the Community Health Worker programme



Policymakers and implementers should consider gender dynamics during both the design and implementation of CHW programs to ensure that policies are more gender responsive and transformative. Gender based budgeting and gender mainstreaming needs to be promoted across all MoH programs.

The decentralization process provides opportunities to increase the responsiveness of the health sector to the differential needs of men, women, girls, boys and people of other genders. Provincial and local levels need support, orientation and training to translate GESI strategy into actionable plans and guidance for implementation at these levels.

It will be critical to ensure that all health systems staff – of any gender, and seniority in health system hierarchies are trained in respectful and gender-sensitive care and understand how gender norms intersect with other social stratifiers (e.g. age, social class, disability, race) to influence different people's use and experience of care. Strengthening monitoring and information system capability to collect and analyse sex-specific and/or sex-disaggregated data and gender equality indicators, and to generate findings to inform planning and programming is also a vital aspect of formulating more gender transformative policies and programs.

Remuneration of FCHVs remains a controversial issue. This all female workforce is providing essential services and remunerating these cadres is essential to advance gender equity and UHC.

Female Community Health Volunteers' as agents of change

In the face of structural barriers and societal norms that perpetuate gender stereotypes, many women and girls continue to suffer discrimination and violence in Nepal. Selected FCHVs, with appropriate training and sensitization, are well placed to influence and change traditional practices in society by introducing adolescents to new ways of thinking and in opening the minds of the people in their communities. FCHVs are now entering politics and taking up leadership roles at the local levels and could be instrumental in breaking down barriers in terms of gender discrimination and inequality. This could include providing education and raising awareness for the prevention of Gender Based Violence (GBV), and counselling and referring survivors, addressing menstrual and postnatal taboos, and preventing child marriages.

Strong beliefs and attitudes held by some FCHVs are a barrier to their acting as role models and addressing gender discrimination in society. CHW cadres and other health care providers should be sensitized about gender and topics such as gender-based violence should be incorporated into pre-service and in-service training to enable these providers identify and respond appropriately. Greater involvement of young people who more open

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to new ideas in the FCHVs role and in working with communities is a way of changing such behavioural patterns and harmful practices. Attracting younger people into the FCHV role and more sensitisation training for these CHW cadres on different sexual identities and of other topics surrounding gender, disability and adolescent health will help to ensure the needs of all groups – disabled, LGBTQI, adolescents- are addressed.

Conclusions

Given the transition to federalisms that Nepal is currently undergoing, continued provision of PHC services and support to preventive, promotive care including the CHW programmes are set to face challenges. These include challenges in the area of health worker deployment, remuneration, ensuring supplies and equipment, and governance and management. Changes are also occurring with the introduction of the professional courses like that of midwifery. However, safeguarding the gains made in RMNCAH outcomes and in continuing to reduce maternal and newborn morbidity and mortality would need continued investments in ANMs and FCHVs.

Policy brief for Nepal

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

For Further Information:
UNICEF Regional Office for South Asia (ROSA)
P.O. Box 5815, Lekhnath Marg, Kathmandu, Nepal
Tel: +977-1-4417082 Email: rosa@unicef.org
Website: www.unicef.org/rosa/