People inhabiting countries of WHO’s South-East Asia Region are today at a critical juncture as they cope with burgeoning economies, rapid modernization and urbanization as well as extreme climate changes, all of which are affecting their lives and their health. At the same time they have limited access to health care facilities which are too stretched, technology-driven, expensive and out of reach for large segments of the population. Today over 600 million people in the Region live in over-crowded and under-serviced urban areas, and a quarter of them are estimated to be poor.

The Region is also in the midst of a demographic and epidemiological transition. While life expectancy has increased, unhealthy lifestyles are leading to an increase in chronic, noncommunicable diseases in epidemic proportion. In many countries, while large investments are being made to strengthen tertiary care, basic health care is often out of reach for many. In this context, community education in the public health aspects of promoting health and preventing disease becomes even more important today.

Countries are mandated to provide adequate and appropriate health care for all, in an equitable manner. The health for all movement had provided the impetus to work towards universal health care. Many countries created cadres of health workers based in the community. In addition, the spirit of volunteerism is strong in South-East Asia – in many countries a large number of people serve as health volunteers. All countries in the Region are committed to the principles of primary health care and have made large investments to support the principles of providing universal health coverage, equity and involvement of the community.

In any system, the community-based health care provider has an important role – which countries need to redefine to meet the emerging health challenges. While community health workers are valued in all countries of the Region, their status within the health care chain varies from country to country.

Community-based health workers and volunteers are uniquely placed in countries of our Region as they are from the community and are therefore sensitive to the socio-cultural milieu in which they operate. The community more readily accepts the preventive and curative services offered by them as they are delivered with empathy. However, their role needs to be redefined
from the earlier focus on maternal and child health, and immunization, to a stronger focus on health promotion and disease prevention.

It is time that health policies in countries find a strong and well defined role for these categories of workers. To use them optimally these health workers must not be isolated or left to function as stand-alones. They must be firmly placed as an important link in the health care and delivery chain, so that they are recognized, supported and nurtured by the system.

This issue of Health in South-East Asia carries some examples of experiences in strengthening the community-based health workforce and successes achieved by community health workers in countries of the Region, clearly demonstrating their vital role in achieving the goal of health for all.

Samlee Plianbangchang
Regional Director

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Taking healthcare to the people in Timor-Leste

Dr Nelson Martins, MD, MHM, GCertPH, PhD, Minister of Health, Republica Democratica de Timor-Leste, Dili, Timor-Leste

Associate Professor Lyndal Trevena, Sydney School of Public Health, Associate-Dean (International), Director, Office for Global Health, Sydney Medical School, NSW

Since almost a decade Timor-Leste has been an independent nation. Its one million plus population has largely returned to living in the 13 remote mountainous districts following a period of instability which displaced many. Poverty continues to be a major issue for remote communities with recent government estimates suggesting that 41% live below the national poverty line of $US 0.88/person/day. National household surveys between 2003 and 2008 describe significant problems for these remote communities to access health facilities when ill and virtually no capacity to engage in preventive health activities. One-quarter of households had to travel more than two hours to their health facility, usually walking across mountainous terrain and often isolated by landslides and flooded rivers in the wet season. One in ten households did not consult any health provider when sick. Distance (64.1%) and transport difficulties (43.4%) were the most common reasons for not seeking help.

Over the past decade Timor-Leste has established a tiered health system featuring one national tertiary hospital, five district referral hospitals, a community health centre in each sub-district and several health posts in each sub-district. In 2008, the Ministry of Health added a new arm to this system the Servisu Integrado du Saude Comunidade (SISCa) programme to specifically address some of the access problems and lack of preventive health activities facing the nation.

The programme focuses on revitalizing primary health care at the community level and integrates the delivery of a basic service package alongside pro-active preventive health activities. Each
month a health team (comprising a doctor, a nurse, a midwife, a health promotion person etc.) from the community health centre and relevant health post take equipment via four-wheel drive to run the SISCa programme on a rotational basis, village by village. Most areas have electricity only for limited hours each evening, poor mobile phone coverage, and limited clean water supplies.

The SISCa programme has two underpinning values – health as a human right and community empowerment. The Constitution of Timor-Leste supports health as a human right and the SISCa programme provides services without charge and aims to reach all communities. Community health workers receive a small payment for their assistance in mobilizing communities and to set-up the SISCa at a venue selected by the community. Dialogue with the community’s chief and council is encouraged to identify local issues and facilitate local solutions. Community support for SISCa is high and in 2010 almost half of infants, almost one-quarter of children under five and 10% pregnant women participated.

SISCa has six structural components:

1. **Family registration:** Each village should have a register for every household which includes key demographic and health data for each household. It can be updated regularly with new births, deaths and cases of malnutrition, TB or malaria. This register forms the denominator in the ‘library’ of manual registers maintained at the community level.

2. **Nutrition assistance and child health promotion:** Mothers are encouraged to bring all children under five to be weighed and measured. Underweight and malnourished children are treated and referred. Data is recorded in the patient-led record (LISIO) and in the nutrition register. Children receive immunization, vitamin A and mebendazole. Immunization coverage is now over 60% and the number of children weighed has increased from 14% to 21% over the past five years.

3. **Maternal health and family spacing:** All pregnant women are encouraged to avail antenatal care and a range of family spacing options with counselling is available. Data is recorded in the patient-held LISIO and in the birth cohort register. Home visits to postnatal women can be made and antenatal care is now 86% (from 61% in 2003) and postnatal care...
has increased from 14.6% to 32.1%. Attended births have increased from 18.4% to 29.9% during the same period.

4. **Hygiene, sanitation and malaria prevention:** Community workers complete a household survey covering water and sanitation and bed-nets are distributed under this head. The survey results contribute to the ‘library’ of registers discussed earlier.

5. **Ambulatory primary care:** A doctor or nurse can assess and prescribe basic treatments for the sick, referring them on as appropriate. Active case finding for TB and malaria can be performed with spot sputum collection and rapid tests for malaria.

6. **Health promotion activities:** Posters, talks, flipcharts and films are shown to the community covering important health topics such as attended birth, family spacing, healthy eating etc.

The functional elements of the SISCa programme are crucial to revitalizing primary healthcare. The library of registers allows local health-workers and communities to proactively monitor and respond to local health needs. Reflection on trends in key indicators can be a powerful tool for quality improvement and active case finding and management of infectious diseases is the third aspect of this ‘functional’ interactive aspect of the SISCa concept.

Although there has been strong community support for the SISCa programme and visible results in improved health, the system needs further strengthening in order to reach its full potential. Ensuring reliable medication and equipment distribution to meet demand and supporting remotely located health staff are important for the future. Facilitating community empowerment takes time and deliberate efforts by health-workers and communities themselves. The programme’s ambitious vision to incorporate data collection and feedback is particularly challenging in a resource-poor environment but with the appropriate support could be a powerful driver for change.
In Thailand, as in many countries in the South-East Asia Region, there has been a rapid increase in the number of people suffering from diabetes. The figures increased from 2.3% in 1991 to 6.9% in 2009. Despite the availability of considerable information about diabetes, eight out of ten patients in rural areas in Thailand were unable to control their blood sugar levels.

Studies in Thailand and preliminary surveys have shown that a majority of diabetic patients lack adequate skills and the confidence to control their diabetes. Most health education provided to the patients could not help to increase their perceptions and skills in diabetic management. About two-thirds of the patients are unable to control their diet and more than one-third do not exercise adequately. Diabetic patients need to be educated and empowered to be able to effectively control their diabetes.

Village health volunteers (VHV) appeared to be the perfect choice for this task. Since 1978 the VHVs have been an important part of Thailand’s primary health care system. They function as a link between communities and health care providers. Currently, there are over 800 000 VHVs whose role is to provide health information to communities. They also help local health staff in immunization, maternal and child health campaigns and undertake simple tasks as taking temperature, measuring blood pressure, simple wound dressing, and simple first aid. VHVs support, motivate, and build the capacity of individuals and the community including patients with chronic conditions in self-care. They also ensure that services needed by the patients are provided.

However, prior experience showed that VHVs’ skills in educating and empowering people needed to be enhanced. The volunteers were

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Faculty of Public Health, Mahidol University, Bangkok, Thailand
provided additional training to build their capacity in a range of skills to deal with diabetes. Their knowledge about diet, exercise and stress management for diabetic patients was refreshed and updated and they were also trained to develop skills like inclusive problem solving and planning; facilitation and motivation; and networking. These skills helped the VHVs to motivate diabetes mellitus type 2 patients to develop and maintain healthy eating and exercise behaviours for diabetes management. The project was supported by Peers for Progress, the American Academy of Family Physicians Foundation.

After the training, VHVs, supported by health staff, worked with patients in groups to identify health and behavioural problems and causes; set appropriate goals; identify means to achieve these goals and to identify methods to evaluate their actions. Each patient was given a personal record booklet as a tool to motivate and monitor them.

Every two weeks the VHVs and the patients met at the health centre to discuss their progress and setbacks. Local health staff were also present to provide additional information or advice, if needed. After discussions, everyone would exercise and then cook a healthy meal which was served for lunch. These activities helped to create a supportive network among the patients.

VHVs in near-by villages worked as a team (usually 3-4 members per team) to visit patients under their care. During every home visit the VHVs would take the patient’s blood pressure, and maintain a record in their handbook. They
would discuss the progress or any obstacles in diabetes management. For problems beyond their capacity, the VHVs would call the local health staff for help and advice.

Group exercise for the patients and the VHVs was organized daily at a peer’s house where patients could take turns to join in.

A community organic garden was developed using land provided by the local administration. An innovative exercise for the patients was the use of a bicycle, which also generated electricity which was used to water the garden.

This project was carried out in two provinces in Thailand which reported the highest percentage of diabetes mellitus – the northeast region and the central region.

The project was undertaken for six months from June 2010 to December 2010.

**Results**

The project was rated as a success given the overall positive results and the appropriateness of the strategies which were suited to the social-cultural context and lifestyle of both patients and VHVs. Eating and exercise behaviour among the patients improved significantly. They exercised for longer durations and their body weight reduced significantly. The body mass index reduced from 26.5 to 24.9. There was a significant decrease in their blood sugar levels from 8.13 mmol/L to 7.6 mmol/L and more than 40% of the patients could keep it within the acceptable range.

**Key success factors**

- Kinship: VHVs have existed in the community and many are related to the patients. This has facilitated VHVs’ support to the patients.
- Strong connection between VHVs and health staff facilitated the continuity of care for the patients, at community, primary and higher levels of care.
- Caring attitude and commitment of VHVs in taking care of the patients helps to sustain the activities.
Creating the patient network enables patients to support each other. The VHV network is an important means for VHVs to share their experiences and to support each other. VHVs used creativity to make activities fun and attractive to the patients such as community garden and bicycling for watering the garden.

Challenges
- Sometimes patients doubted the credibility of the VHV and resisted in following their advice. The VHVs then called in the health staff to reinforce the advice given by them. This effectively convinced the patients and strengthened the position of the VHVs.
- Educating and empowering communities is a complex task. Much more needs to be done to enhance the capacity of the VHVs by providing them additional training, specifically for diabetes control as well as exposure to examples of real-life situations and coaching on ways to deal with situations.
- Dealing with cases of adamant, severe diabetes, including some with amputations and hard-to-control diabetes was another challenge faced by VHVs. In such cases support from other patients and health staff worked well.

Future plan
Both VHVs and health staff would like to continue with this work and in the future they would also like to involve local administrative bodies in their implementation. The funding agency expressed its interest in supporting the implementation of the project in other areas. The advocacy activities will be done through technical conference such as South East Asia Primary Health Care Innovations Network, Quality of Life Foundation, and the Ministry of Public Health, and publications.
Background

The National Rural Health Mission was launched in 2005 to rejuvenate the rural health care system in India. The mission began with 18 states and now covers most of the country. A core component of this effort is ASHA (Accredited Social Health Activist. Asha also means hope). She is a catalyst of change at village level and is the active interface between the community and the health system. It is now mandatory for every village to nominate a woman with background of community work and basic education as an ASHA.

The ASHA is a community volunteer whose main role is that of a social mobilizer, pushing the demand for health services. While a large portion of her work is related to maternal and child health (MCH), in different states she also works for key priority programmes, e.g. immunization, DOTS compliance/completion and for testing and treatment for malaria, among others. She often accompanies the patient to the health centre for treatment, and is remunerated through performance-based incentives provided by the programme.

Overall, her role includes:
- Building awareness on health and, particularly its social determinants
- Mobilizing the community towards indigenous health planning
- Increasing utilization and accountability of the existing health services
- Promoting good health practices in the community
- Providing a minimum package of curative care as appropriate and feasible for that level
- Undertaking timely referrals

ASHA – A beacon of hope

Mr Alok Mukhopadhyay, Chief Executive, Voluntary Health Association of India, New Delhi
The ASHA has been placed in the community with links to other community health workers. She is tasked to work closely with the auxiliary nurse midwife (ANM) and they jointly organize checkups of pregnant women including their transportation for safe institutional delivery to a pre-identified functional health facility. They could also think of organizing health insurance at the local level for which the medical officer and others would provide necessary technical assistance.

Each ANM holds a monthly meeting with the five to six ASHAs stationed in the villages of her work area. This is held at the Anganwadi Centre during the monthly Health and Nutrition Day to assess the quality of the ASHA’s work and to provide them guidance.

The ASHA is also included in the monthly meetings held by medical officers managing the PHCs which include the ANMs and block facilitators etc. The health status of the villages is carefully reviewed and payment of incentives to ASHAs under various schemes is organized simultaneously. These meetings are also an opportunity to assess the support received from the Village Health and Sanitation Committee and their involvement along with replenishment of ASHA kits.

Management support is to be provided to the ASHAs from several levels. The officials of the Integrated Child Development Services (ICDS) are expected to offer full support to ASHA activities. The management support at the block, district and state level are to be fully utilized in creating a network for support to ASHA including timely disbursement of incentives, redressal mechanisms, databank on all ASHAs, quality of their output and the outcomes of periodic health surveys of the villages to assess the impact of these female community volunteers.

After selection, every ASHA undergoes a series of trainings to acquire the necessary knowledge, skills and confidence for performing her defined roles.
performing her defined roles. The induction training is completed in 23 days spread over a 12-month period. Additionally, for two days in every alternate month, training and interactive refresher courses are held to upgrade their knowledge and skills, and to maintain their motivation and enthusiasm. The meetings also serve to monitor their work and to troubleshoot any problems they face. The ASHAs are compensated for attending these meetings.

The ANMs during their outreach sessions in the villages contact the local ASHAs and provide them with continuing and updated education. Sometimes, NGOs are also invited for training and post-training follow-up.

Training materials including a facilitator’s guide, other aids and resource materials are provided to the ASHAs, together with a periodically-replenished drugs kit. The training materials produced at the national level serve as a general prototype which the states modify and adapt as per local needs. Arrangements have also been made for their continuing education and skill upgradation. A district-based resource agency (preferably an NGO) is identified by the State to work in collaboration with open schools and other appropriate community education schemes to develop relevant illustrated material. This is periodically mailed to those ASHAs who opt for an eventual certification.

Till March, 2010, over 351,000 ASHAs had been selected from various States. Today the number has risen to 800,000 ASHAs.

**Experiences**

- Smooth collaboration of ASHAs with self-help groups, ANMs, health facilities and “panchayats” is essential for their optimum functioning.
- ASHAs who are unable to earn the confidence of their community representatives and volunteers may face obstacles in their work.
- There needs to be regular evaluation and monitoring of the ASHAs’ work by State authorities. In the absence of this, a health activist would be unable to meet the programme objectives.
- After the initial phase of training, follow-up sessions are important to keep ASHAs updated on the new information, evidence and knowledge of promotive and preventive aspects of public health. Training of trainers is necessary to pass on skills to other able members of the community and for creating new volunteers.
- The ASHAs need active support from Village Health Sanitation Committees. Unfortunately in many “panchayats” these committees are not fully functional.
- The current system of monetary compensation and incentives needs to be re-examined if we are to succeed in our effort to recruit a large number of ASHAs from economically weaker communities.
- The support structure of ASHAs needs further strengthening with active involvement of civil society.
Community Health
Workers in Action
Sweety Akter is a community health worker in BRAC’s maternal, neonatal and child health (MNCH) programme. At BRAC such workers are called *Shashthya Kormi*. They provide education and health services to pregnant and lactating women, newborns and children at home. Sweety lives in Goshaigonj, a small village in a remote rural district in north Bangladesh.

Sweety’s father, Mohammad Safiur Rahman, is a poor farmer. She is the second of four daughters. Like most traditional families her father desired a son and Sweety’s grand-parents and neighbours all blamed her mother for not having a son. To fulfill their desire her mother conceived for the fifth time and gave birth to a son. The family was overjoyed, but unfortunately this was short lived as the baby developed complications after birth which the traditional birth attendant was not able to recognize in time. The baby was taken to hospital where he died.

According to Sweety, “From my childhood I have always heard about the death of my brother. My poor mother always remembers him and I see tears in her eyes every time she talks about him.”

This painful family event left a deep impression on Sweety’s mind, and raised in her the determination to serve the community. She said, “Whenever I used to hear this and similar stories I longed to do something for such mothers and to save the lives of their young babies.”

Like most parents, over time, Sweety’s parents also became concerned about getting her married. However, during her 7th grade in school, Sweety had become a member of the “Kishori Club” (Adolescent Club established by BRAC) in their village. She had learnt about the adverse effects of early marriage and adolescent pregnancy and decided not to get married at a young age. When Sweety told her parents about her decision they were very annoyed. Her struggle to avoid an early marriage succeeded three times but unfortunately she lost out when the fourth marriage proposal came.
In 2003, when she was a student of class eight, Sweety was married to Mohammad Mokhleser Rahman. Her parents-in-law promised to allow her to continue her studies. Sweety’s husband is a farmer, and it was very difficult for him to bear the family’s expenditures with his meagre income. To support the family’s finances, Sweety joined BRAC’s non-formal primary school as a teacher in 2004.

As she did not want to become a mother till she was 18 years old, Sweety started to use family planning methods to delay pregnancy. But her husband’s family wanted a child soon, and so she was pushed into early pregnancy. Her first daughter was born in February 2005 when she was to appear for the final exam of the Secondary School Certificate (SSC). She sat for the exams, just seven days after her delivery but unfortunately she failed. She became depressed but did not lose her determination and started to prepare for the examination again. She successfully cleared her SSC in 2006. Although Sweety was eager to go to college, she could not as the family did not support her.

For Sweety, 2006 was to be a momentous year. The death of her elder sister, Beauty Begum, due to post-partum haemorrhage (PPH) after delivery was a great shock for her. In the meantime she heard that BRAC was to start a new project named “Maternal, Neonatal and Child Health” under which a number of community health workers would be recruited. She realized that this would be a great opportunity to fulfill her wish to work for saving lives of mothers, newborn babies and children. She, therefore, applied for the post and was selected as a Shashthya Kormi in August 2006.

BRAC’s health programme employs two types of community health workers - about 88,000 Shasthya Shebikas and about 7000 Shasthya Kormis, countrywide – nearly half of whom work in the “improving maternal, neonatal and child survival” (IMNCS) project.
In Sweety’s own words, “I became interested when I heard that this project aimed to save mothers, newborns and children; I want to do this work. If I can save a single life of a mother or a newborn by providing health care services, it would be a great achievement for me. This will make my mother happy, and the souls of my sister and my brother will be pleased.”

All the community health workers are selected from the community with community acceptability as a key criterion for their selection. Sweety took her job very seriously and worked hard. Each Shasthya Kormi covers around 1500 households and provides antenatal and postnatal care to mothers and newborns, and counsels and ensures exclusive breastfeeding and infant and young child feeding practices.

Like all CHWs, Sweety was provided basic training at the local training centre. The training included sessions on technical topics (programme issues as well as basic knowledge on health and nutrition) and field operations are carried out at local training centres. The duration of the training varies according to the level of workers. Besides this, all Shasthya Kormis receive four weeks basic training and regular, periodic refresher training as well as training to update their technical knowledge.

In 2010, Sweety learnt that BRAC would begin training of community skilled birth attendants (CSBA). She discussed this with her husband and with the BRAC staff and expressed her interest in getting this training. With support from her family, Sweety successfully completed the six-month training course for skilled birth attendant. She has started working as a CSBA from April 2011. The CSBAs offer skilled delivery care and neonatal care during home delivery. This cadre is paid 1200 BDT (Bangladesh taka) per month. Performance-based incentives are given to all types of CHWs in order to enhance their engagement with the project.

After her first 11 deliveries she has the confidence to provide skilled assistance during delivery. Sweety says, “My brother and sister died due to unskilled attendance during delivery. I realized the importance of skilled attendance at every childbirth as in my village most of the mothers give birth at home. Now I am working as a CSBA and am committed to ensure that I won’t let any sister die during child birth, nor hear any mother cry for her child.”
Since its establishment in 1974, the Royal Institute of Health Sciences has been producing community-based health workers (CBHW) such as health assistants, auxiliary nurse midwife and basic health workers with a basic training of two years in medical and public health related fields. These health workers form the backbone of the health services delivery system in the country.

With the country’s fast developmental progress in the past decades, many new health centres have been established and new practices and technologies introduced. People’s lifestyles have changed increasing the burden of non-communicable diseases. Road traffic accidents and pollution-related problems are also increasing. Climate change and its effect on health, emerging and reemerging diseases and pandemics such as SARS, avian flu etc. are growing challenges.

Knowledge and technology in the health and medical field have been increasing exponentially facilitated by the rapid advancement and accessibility of information and communications technology.

People’s awareness of health has increased and they are no longer satisfied with simple basic care but demand and expect safe and quality services from health care workers.

Given the above scenario, CBHWs with their basic training were no longer adequately prepared to meet the growing needs, demands and challenges as well as to adapt to the changes. At the same time, there were limited avenues for them to enhance their professional skills as well as advance their career prospects.

Realizing this gap and the aspirations, motivation and dedication of 400-odd CBHWs, the Ministry of Health requested WHO support to launch a Bachelor in Public Health in South-East Asia.
Health (BPH) programme at the Royal Institute of Health Sciences (RIHS) under the Royal University of Bhutan.

As a first step, a training needs assessment supported by WHO was conducted in February 2009. It was found that health workers lacked skills in leadership, planning and management, critical thinking, problem solving and analytical abilities. There was a lack of a systematic continuing education programme to update their knowledge and skills.

Based on those findings, WHO-SEARO provided technical assistance to RIHS to develop the BPH programme. A team from the Faculty of Public Health, Mahidol University, Thailand worked in close collaboration with the faculty from RIHS and the Ministry of Health to develop the curriculum. Three faculty members from RIHS were sent to pursue the Masters in Public Health course at Mahidol University with WHO support. At the same time, senior health managers from Bhutan visited the United States, Thailand and Indonesia to study their public health programmes and examine possibilities for collaboration in faculty exchange and linkages. A team of potential faculty members visited the Faculty of Public Health, Mahidol University to work further on the curriculum and with senior faculty to update themselves. WHO-SEARO experts also reviewed the curriculum and provided valuable comments. The curriculum was finally validated by the Royal University of Bhutan in August 2009 with validation panel members from Bhutan and Thailand. In addition the library and IT resources were also strengthened significantly.

The BPH is a two-year, full-time modular programme offered in four semesters. The intake capacity is 25 students per batch. Incorporating principles of adult-learning, 50% of the course is devoted to self-study and problem-based learning. A substantial time is spent on practical and field exercises. After successful completion, the graduates are expected to take a leadership role in health. The course is designed to enable the health assistants to:

- Empower people to take care of their own health
- The BHP programme will greatly contribute towards improving the quality of health care services and sustaining the motivation and dedication of health workers.

The BPH programme will greatly contribute towards improving the quality of health care services and sustaining the motivation and dedication of health workers.
Communicate effectively with clients and stakeholders
Manage information and its use in evidence-based decision making
Plan, implement and evaluate public health programmes
Build partnerships and collaboration with relevant agencies
Promote health and prevent diseases, injuries and disabilities
Think systematically and critically in their everyday duties.

The BPH programme was launched by Dr Samlee Plianbangchang, WHO Regional Director for South East Asia on 13 April 2010 in a ceremony graced by Lyonpo Zangley Drukpa, the Honorable Minister of Health, the Dean, Faculty of Public Health, Mahidol University, the President of the South-East Asia Public Health Education Institutions Network (SEAPHEIN) and many dignitaries. The first lecture for the BPH students was delivered by the Regional Director.

The BPH programme is truly a big step towards professionalizing the community-based health workforce and marks significant progress towards revitalization of primary health care in Bhutan. It will greatly contribute towards improving the quality of health care services and sustaining the motivation and dedication of our health workers. This is indeed another milestone in the history of the institute and in Bhutan’s health system.

The challenge now is to strengthen the faculty’s capacity both in numbers and qualification. This is being addressed with three more faculty members sent for MPH with WHO support.
Indonesia’s posyandu programme has for years been upheld as an exemplary community-based programme. Started by the government in 1984, this acronym refers to ‘Post Pelayanan Terpadu’ - or post for integrated services. It became very popular with the public since the then President, Mr Soeharto declared it as the key strategy for child development and care.

Each posyandu post provides services related to monitoring mother and child health, nutrition, immunization, diarrhoea control, and family planning. The posyandu volunteers are almost all women. Volunteers are called cadres who are officially assigned by the village or local authority to operate the posyandus. Once every month, cadres hold activities in a place provided by the community. The time is flexible. It could be the first Saturday of the month, every 27th day, or any other day decided by the community. The schedule is synchronized with health workers since they are an important part of the posyandu.

Each posyandu session has at least five cadres to cater to the five essential ‘tables which are set up’. The first table is for registration, the second is for weighing and monitoring children’s growth; the third is for recording the growth into the monitoring card called the Kartu Menuju Sehat (KMS) and fill out the registration book, whereas the fourth table is for counseling and education, particularly in nutrition.

The fifth table is for health workers from the community health centre (puskesmas) or its satellite health centre (pustu). On this table, health workers provide medical examination, immunization, other basic health care, family planning services and when necessary, give education to the community. In some sessions they also distribute vitamin A or implement other health programmes. Some posyandus provide special services for senior citizens.

The most popular table is the one which provides food and education. Here, food such as soy porridge, vegetable rice porridge, and other food items are given free to toddlers. People gather here to chat, and share information while waiting for the health education session.
The number of people utilizing posyandu services varies from place to place. It can vary from 30 to even 100 visitors. To ensure high attendance at the posyandus, cadres initiate events like door prizes for children or “arisan” for mothers. Arisan is an event where people contribute money and they have a lottery to see who receives the pool of money for that month.

From the arisan, a small amount is contributed for the posyandu’s activities. However, the main funds for operational costs come from different sources. Each province or district has its own policy, but, basically the posyandu is funded from the puskesmas or the community health centres. The amount is rather small, less than USD 15. That is why it is often the community which contributes more to the posyandu. It could be in the form of cash or ‘jimpitan’, - a handful of rice. The budget and the operational costs depend largely on the number of members and the community a posyandu covers.

Each province has the authority to decide the volume of the posyandus, depending on the administrative divisions of the area. Each district has regulations on the size of the population to be included in one group.

The head of each village or Rukun Warga (RW) is responsible to support the posyandu. They ensure that the posyandu has a place to hold its activities. This could be in the village office, or in a common building provided by an individual, and sometimes the villagers offer their homes to hold the posyandu.

A posyandu must cover an area with around 50 under-fives, a minimum of five cadres providing health activities and health workers. While some posyandus may have quite ‘sophisticated’ facilities like an oxygen tank, most of the 266,827 posyandus are rather simple. Everything they have comes from the community and everything they do, is for the community.
At the end of the 1990s, there was a decline in the status and activities of the posyandus. Some felt that the movement was dying down. “No. We never died down,” Nurma from posyandu Asih strongly refutes this notion. “We have continuously done what my parents did”. Both her parents were cadres who convinced her to also join. Nurma’s posyandu is 60 km from the capital of Lampung Province which is around half an hour flight from Jakarta, the capital of Indonesia.

After the monetary crisis in 1997 and the political upheaval in 1998, posyandus in some parts of Indonesia stopped their activities. A lot of cadres shifted their priority to working to earn more money to ensure the survival of their families. People focused more on their family’s financial situation rather than on community needs.

Also, with the implementation of decentralization and the increased power devolving to the local authorities, the focus of the local government often shifted to other activities and to other sectors.

When President Soeharto was in power, cadres were an intrinsic part of the political milieu and they were geared towards supporting the government’s programmes. As a reward, the cadres were given some share of political power. However, now that Indonesia has many political parties and more dynamic power positions, the cadres have lost their incentive.

Another contributing factor could be the rapid urbanization taking place in Indonesia. Women live in cities far from their parents. Their morning-to-evening jobs prevent them from coming to the posyandu which mostly open in the morning. They leave their children to their young maids who are often not even aware of the posyandu.

Given the increasing health problems such as malnutrition and emerging infectious diseases, the central and local governments have once again realized the importance of the posyandu as the most functional programme for community health. Many have understood its strengths. Local governments now have more independent power to support their posyandus as they become more local-specific in their programme delivery.

With the programme’s revival, more activities are being added, and often cadres are complaining about the large number of forms they have to fill, like child growth monitoring, nutrition status and environmental health. In some areas the local authority does not invest sufficiently in the posyandu to match the growing demands. They ask the posyandu to do their own resource mobilization. This could prove an uphill task in some of the remote areas, eg. a village like Maubasa, on Flores island which can be reached only by a long journey by air or by boat.

According to one doctor, the success of the posyandu depends much on the managers of puskemas and the local authorities. Today in some districts, the cadres are provided training and the posyandu gets rewarded for the correct filling of forms. But in other posyandus the cadres are provided almost no training and are given no incentives for good work. However, since the posyandu has a proven record for serving the community, the way forward is for the local governments to support its good work to better serve the community.
Nepal has witnessed significant gains in a number of key public health indicators over the past decade. Child, infant and maternal mortality rates have decreased, life expectancy has increased, and total fertility is down, despite a ten-year long internal conflict. However, these gains are countered by regional disparities and increasing inequalities in access and use of some health services. The government faces serious challenges because of the difficult terrain, poor social inclusion of certain population groups, variability in population density, political instability, unequal development, and inadequate health funding. With a tripling of the population in the last 50 years, 40% of the population currently is below 15 years.

The female community health volunteer (FCHV) remains one of the most effective means to deliver primary health care services in Nepal. The Government of Nepal (GoN) established the FCHV Programme in 1988 to mobilize lay personnel to respond to the population’s health needs. Currently, there are 48,549 FCHVs working in 4000 village development committees. This scheme covers all rural areas in 75 districts in Nepal, (but not the urban areas). Their role is to strengthen coverage of government health services and make health systems more responsive to the specific needs of diverse, poor and disadvantaged populations.

Most FCHVs are local women, selected by community mothers’ groups. They are provided 18 days of initial training as well as refresher training every five years.
them have been working for over 10 years and their annual turnover is only about 4%. FCHVs typically serve 50 to 100 households, spend an average of five hours per week conducting health promotion activities, dispensing commodities and practicing limited case-management for simple medical conditions in children such as diarrhoea and pneumonia.

They act as voluntary health educators and promoters, community mobilizers, referral agents and community-based service providers and play a supportive role in linking the community with available PHC services. The FCHVs continue to play an important role related to family planning, maternal/neonatal health, child health and control of selected infectious diseases at the community level. They are seen as key contributors to the reduction in childhood and maternal mortality and morbidity and have contributed to high coverage of important primary health care programmes.

Programmes such as the distribution of vitamin A and de-worming tablets and the polio campaign rely almost exclusively on FCHVs and have achieved coverage rates of 95% and higher. FCHVs also play an important role in immunization coverage. Recently, they have begun distributing iron tablets to pregnant women and antenatal iron use has increased to 59%, compared to 23% in 2001. A recent systematic review by Lewin et al. concludes that the use of lay or community health workers (CHWs) can lead to significant health benefits.

For most women beneficiaries the FCHVs are much valued as they are often the only health workers ‘available’ during emergencies, given the widespread absenteeism of health care workers at health facilities.

FCHVs are not paid salaries but receive some in-kind incentives from the health ministry including direct payment for specific activities. These include transport stipends, access to FCHV fund, dress allowance and free medical treatment up to district level hospital.

Given the voluntary nature of the workers, the programme’s achievements have been remarkable against a scenario marred by political instability, civil war and frequent changes of government.

There are several challenges facing the programme which need to be urgently
addressed. The success achieved by FCHVs has meant that they have got overburdened by numerous community level extension tasks by both governmental and nongovernmental organizations. However, evidence shows that programme coverage and effectiveness of the FCHV decreases rapidly with increased catchment population and the number of tasks assigned to them.

Besides this, through FCHV associations, which have links with trade unions the FCHVs now expect regular salaries and better working conditions. These questions will need to be addressed.

The MoHP has identified several steps to further strengthen public health initiatives by strengthening the FCHVs and their capacity and network:

To provide the services of FCHVs in urban areas as well, an additional 4000 FCHVs will be selected by mothers’ groups. The process will use revised selection criteria to include higher literacy requirements. They will also be provided adequate training in the 58 municipalities in close coordination with the Ministry of Local Development and Municipalities.

To ensure that FCHVs can adequately treat all children, particularly for diarrhoea, efforts will be made to ensure provision of adequate medical supplies particularly ORS.

To strengthen the FCHVs’ capacity for safe pregnancies and delivery and child health care and to enable them to better promote community-based maternal and newborn care, the FCHVs will be provided with additional training.

To ensure their high performance and low attrition, the FCHVs need to be better supported and motivated. They need to be encouraged both through human resource development strategies as well as with adequate and sustained financial or non-financial, context-specific incentives.

In the long run, the FCHVs will be able to achieve their goals only when there is assured presence and performance from other health workers at the health facilities. Given the FCHV’s T0Rs, low exposure to formal education, training, and incentives, it would be counter-productive and exploitative to shift tasks meant for paid health workers to unpaid volunteers.