Strengthening Community-based Health Care Services: Report of the Technical Consultation

WHO/SEARO, 15–16 June 2015
Technical Consultation on Strengthening Community-based Health Care Service Delivery
WHO-SEARO, New Delhi, India
15-16 June 2015
Strengthening Community-Based Health Care Services

Report of the technical consultation
15–16 June 2015, WHO/SEARO, New Delhi
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Acronyms

AMR      Antimicrobial Resistance
ASHA     Accredited Social Health Activists
BSP      Basic Service Package
CBHW     Community-based health workers
CCs      Community Clinics
CHV      Community health Volunteers
CHWs     Community Health Workers
FTHW     Formally Trained Health Worker
GDP      Gross Domestic Product
HF       Health Facility
HIV      Human Immunodeficiency Virus
ICT      Information and Communications Technology
MCH      Maternal and Child Health
MDG      Millennium Development Goal
MNCH     Maternal Newborn and Child Health Programme
MOH      Ministry of Health
NCD      Non-Communicable Diseases
NGO      Non-Governmental Organization
PDAs     Personal Digital Assistants
PHC      Primary Health Centre
SDGs     Sustainable Development Goals
SEAR     South East Asia Region
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>SISCa</td>
<td>Integrated Community Health Services Project of Timor-Leste</td>
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<tr>
<td>SMS</td>
<td>Short Message Service</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>VHWs</td>
<td>Village Health Workers</td>
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Executive Summary

2015 marks the transition from the MDGs to the sustainable development goals (SDGs). The targets for the SDG health goal include universal health coverage (UHC), to which SEAR Member States have already committed. Community-based services are a vital – and fast-changing – component of UHC. Current issues facing community-based services include a greater focus on tackling non-communicable diseases, a sustained interest in developing models for urban populations and recognition that community-based health workers can play a significant role in successful emergency responses to natural disasters.

Different approaches to delivering community-based services exist, including programme-specific community health workers; outreach services and community-based multidisciplinary teams. Important policy questions include: what opportunities exist for greater coordination around peoples’ multiple health care needs? How do community-based services connect with the rest of the health system, and what support systems do they need?

In 2014 the 67th Regional Committee agreed that the subject of the next technical discussion, before the 68th Regional Committee, would be community-based health care services. This is the report of that Technical Consultation, which took place in June 2015.

Main messages from the Technical Consultation

(1) *With the transition from the MDGs to the SDGs,* the commitment to universal health coverage, and the renewed emphasis on addressing inequalities, community-based services will continue to play an important role in future health systems.

(2) *It is important to look at community-based services as a whole* – as a system or level of care within which a range of services are delivered, by a growing range of health workers from volunteers to salaried professionals. Community-based services are an important part of the wider health system, as well as being part of community.
Community-based health services are a necessary part of advancing universal health coverage, because they can increase access to needed services especially for hard-to-reach groups. However, they are not always visible to decision-makers, especially at national level.

The range of health services provided at community level keeps changing and evolving, as health needs change. There is an increasing focus on noncommunicable diseases. These newer services are different from the more traditional ones covering maternal and child health (MCH) and communicable diseases, because they often require a circle of identification at the community level, referral for formal diagnosis and initiating treatment, and then follow-up at community level.

To strengthen community-based health services, changes in the types of services provided need to be supported by changes in workforce training and supervision; medicines; financing; policies; legislation and access to new technologies. Developments in information and communications technology (ICT) are potentially very useful for community-based services, but scaling up small-scale ICT schemes is challenging.

In many situations there appears to be a trend to “regularize” the employment of voluntary (or quasi-voluntary) providers. “Regularization” involves becoming a recognized part of the overall health system.

Different approaches to community-based services are needed for different types of populations, for example peri-urban communities, migrant workers, remote populations and socially marginalized groups.

There are some information gaps about community-based health services, but more importantly a lot of information exists that is not used as well as it could be. Monitoring the full range of services would be useful, for example, through a ‘UHC scorecard’. Social audit has a role to play.

There are some important evidence gaps. Evaluations of the different models developed in different countries and their impact on results would be useful. There is insufficient information about the costs and cost-effectiveness of community-based services.

Community-based health workers of all types can play an important role in emergencies.
Recommendations/Action Points

Recommendations for Member States

(1) Ensure community-based health services are adequately reflected in national and sub-national health strategies, plans and budgets.

(2) Develop emergency preparedness capacity in community-based health workers, whether formal health workers or voluntary community health workers.

(3) Synthesize existing information across community-based services as a whole, presented in ways that are easy for decision-makers to interpret.

(4) Consider ways to improve the national evidence base on different approaches to community-based service delivery, and their results, including how to ‘go to scale’ where appropriate.

Recommendations for WHO

(1) Develop a set of guiding principles for framing analyses of community-based health service delivery systems.

(2) Improve the regional evidence base: by encouraging national research on the impact of different models of community-based health services; by using tracer conditions such as diabetes to document approaches across a number of countries; by bringing together evidence from other regions – and present this in a way that is useful for SEAR countries.

(3) Encourage inclusion of community-based services in policy dialogue about UHC and support countries to ensure that community-based health services and systems are adequately reflected in new National Health Strategies.

(4) Support countries to further develop emergency preparedness in community-based health workers, whether formally trained or community health workers.
Report of the Technical Consultation

1. Background and objectives

2015 marks the transition from the MDGs to the SDGs. The targets for the SDG health goal include universal health coverage, to which SEAR Member States have already committed. UHC is about increasing all people’s access to care that they need, and about protecting them from being impoverished as a result of health care. It includes a fundamental concern with reducing inequities in access to care.

There is a long history of community-based services across priority programmes in South-East Asia, from which to draw lessons for the future. Community-based services have been an important part of successful eradication programmes, and in improving access to maternal and child health care, TB and HIV treatment. There are shifts in what services are being offered within these programmes, for example, new TB notifications or community-based HIV testing. More recently they have been part of the response to tackling noncommunicable diseases, e.g. community-based NCD detection; mental health care, palliative care and rehabilitation. They have been used to reach selected populations in both urban and rural areas. They have played a significant role in successful emergency responses to natural disasters.

Different approaches to delivering community-based services exist, including programme-specific community health workers; outreach services and community-based multidisciplinary teams. New technologies such as mHealth are being used in the community. Important policy questions include: what opportunities exist for greater coordination around peoples’ multiple health care needs? How do community-based services connect with the rest of the health system, and what support systems do they need?

In 2014 the 67th Regional Committee agreed that the subject of the next technical discussion, before the 68th Regional Committee, would be community-based health care services. A background paper was prepared in advance of the consultation (see Annex 1).
Objectives of the consultation

Within the frame of universal health coverage and the post-2015 SDG agenda:

- To review what is known about trends in the use of community-based services to deliver priority health interventions
- To review experience with different approaches to delivering community-based services, and draw lessons for their role in advancing UHC including integrated service delivery
- To agree on a set of practical recommendations for the next Regional Committee.
2. **Introduction to the Consultation**

The Technical Consultation on Strengthening Community-based Health Care Services was held on 15 and 16 June 2015 at the Regional Office for South-East Asia (SEA) in New Delhi, India. Experts in community-based service delivery from all Member States were invited. International and regional experts and a number of WHO Regional and Country Office staff also participated. The meeting was co-chaired by Dr Palitha Abeykoon, Chairman, National Authority on Tobacco and Alcohol, Sri Lanka and Dr K Ellangovan, Health Secretary, Government of Kerala, India.

2.1 **Opening remarks by the Regional Director**

Dr Poonam Khetrapal Singh, Regional Director, WHO SEARO gave the opening address. She explained that the 67th Regional Committee in 2014 had selected community-based health care services as the topic for a regional technical consultation – India had proposed the topic, supported by Bangladesh, Maldives and Sri Lanka. She emphasized that conclusions from the Technical Consultation would be presented to the next Regional Committee in September 2015. She noted that this year’s technical discussions were building on the related topic of community health workers, which had been discussed in 2011.

The Regional Director reminded the group that 2015 marks the transition from the MDGs to the SDGs, and that the SDG health goal includes UHC – an important priority for all SEAR Member States. She stressed that UHC includes a fundamental concern with reducing inequities in access to care, and that community-based health care services are an essential link in the service delivery chain for many health priorities.

Dr Singh noted that although there is extensive provision of community-based services in the South-East Asian Region, there is little documentation of community-based service delivery as a whole, and what it achieves.
2.2 Scene setting for the Technical Consultation

Dr Phyllida Travis, Director, Department of Health Systems Development, WHO SEARO, then set the scene for the technical discussion. She reiterated the Regional Director’s point that the SDG health goal includes universal health coverage, and that UHC entails effective coverage of health services alongside financial risk protection. Coverage can take many forms, but will always include some community-based services. She noted that, despite progress in recent years, recent data show that many people in the South-East Asia region still do not receive the services they need.

She stressed that achieving UHC in a country is a gradual process. It is about making available an evolving range of preventive, promotive and curative services, including palliative care and rehabilitation. Each country has a different starting point in terms of its disease profile, gaps in service coverage and level of health spending. However, whatever the circumstances, community-based services are a vital component for achieving UHC.

Finally, Dr Travis drew attention to the background paper for the meeting, as the meeting agenda had been organized around five sets of strategic questions about community-based health services identified in that paper. The paper is given in Annex 1 of this report.
3. Technical Discussions

3.1 Session 1: What are community-based health care services, and who currently provides them? How much information do we have on overall patterns and trends? How is this being used by decision-makers?

The background paper identified that little is written about community-based services as a whole, in contrast to the extensive literature about other types of services such as hospitals or primary care facilities. Whilst there is a sizeable literature about Community Health Workers (CHWs), there is little systematic documentation about the whole range of services now being provided by a variety of workers in the community. There is also a lack of standard definitions. Presentations about Timor-Leste, India and Bangladesh gave useful illustrations of the different ways different countries are delivering community-based services.

**Timor-Leste** has a programme of integrated community health services known as SISCa (see Figure 1), which was presented by Ms Isabel Maria Gomes. Its aim is to provide integrated services at the level of the lowest community unit (Aldeia). Provision is based on a Basic Service Package (BSP) that includes health promotion. SISCa has an important element of population-based data collection, with a particular focus on target populations such as children and pregnant women. SISCa is implemented by Community Health Volunteers in partnership with health staff from the local Community Health Centres and Health Posts. The Volunteers are selected by their own community and registered by the Ministry of Health. They participate in periodic trainings organized by the Ministry.

The major challenges encountered by SISCa include: low levels of community participation, a high turnover of Volunteers (who want incentive payments and formal employment status) and frequent changes in leadership of the programme.
Dr Rajani Ved presented the role of the ASHA in community-based health care services from India. ASHAs are community health workers with three roles: facilitator, mobilizer/activist, and community level care provider. There are almost 860,000 ASHAs. A support system has evolved at sub-block, block, districts and state levels. Lessons from the first 10 years of the ASHA programme:

- ASHAs play an important role particularly for institutional deliveries, newborn and child health care, nutrition, malaria and TB. Their exact roles vary across districts, depending on access to and quality of local health facilities. In some areas ASHA are taking on new roles: non-communicable diseases, palliative care and acting as first responders in disaster situations.

- Sound procedures have developed for local selection of ASHAs, training in a set of specific competencies and skills, and field based, hands-on mentoring and supportive supervision. There is a system of performance-based incentives. ASHA accreditation is now being introduced.
ASHAs can be an effective bridge between the formal health services and the community.

Five main challenges for the future were identified:

- ICT has the potential to strengthen the work of ASHAs. However this requires making the right decisions about exactly what technology to use across the programme.
- Turnover of ASHAs needs to be managed efficiently to minimize gaps in service provision.
- Systems for training, support and payments need to be institutionalized and be of a consistent standard. There are currently major differences in quality in different parts of the country.
- Establishing performance improvement systems that recognize that some outcomes are beyond the control of ASHAs.
- Balancing community embeddedness with an expanded role and reasonable financial incentives. This balancing act is illustrated in Figure 2.

**Figure 2: Balancing expectations and volunteerism: the ASHA programme in India**

*Courtesy: Dr Rajani Ved, India*
Dr Liaquat Ali Khan from Bangladesh illustrated a different model of expanding health coverage in hard-to-reach rural areas by increasing the number of community clinics. Bangladesh planned 13 500 clinics, with an additional 361 in 2013 for rural and hard-to-reach areas. By 2013, 13 000 community clinics had been established, each serving a population of 6000. Clinics are seen as a necessary part of ensuring that services are available “at the door-step of the community”. They are intended to provide a range of services, including maternal and neonatal health care, integrated management of childhood illness, family planning, immunization, screening for NCDs (e.g. diabetes), nutritional education and micronutrient supplements, treatment of minor ailments and common diseases, and effective referrals. Normal deliveries are conducted in community clinics: in 2014, there were over 6600 deliveries, though this is still a low fraction of all deliveries in Bangladesh.

Three health workers are based in these clinics: a community health care provider, a health assistant and family welfare assistant who both spend half their time in the community rather than in the clinic. Community groups have also been created. A large number of NGOs support capacity development of the community health care providers and community groups.

Four major challenges were identified for the future expansion of CCs:

- The involvement of communities and local government needs to be strengthened.
- It is a major task to train all the female community health care providers to become skilled birth attendants.
- eHealth needs to be scaled up.
- Referrals need to become more effective.
A number of themes emerged from the lively discussion following the presentations, which were initiated by Professor Sanjay Chaturvedi from the University College of Medical Sciences, New Delhi.

- **Clarity of roles** is important otherwise there can be hidden gaps and duplication in service provision.

- The **financial sustainability** of programmes. Community-based services in Timor-Leste are provided by salaried staff, and there are significant inputs from international partners. In contrast, for the ASHA programme in India, which is funded through domestic resources, the challenge is to provide ASHAs with fair recompense when they are taken away from hours of paid employment, without making the system financially unsustainable.

- The **quality of care** provided by community-based health workers is important, but is often not closely monitored. There are particular concerns about them dispensing medicines without following standard protocols, and increasing risks of antimicrobial resistance (AMR).

- **Community engagement** was acknowledged to be a challenge in all three countries, with disappointing levels of participation.
Finally, there was an important discussion about the **definition** of “community-based health care services”. The background paper suggested the following definition: “all services provided by people who spend a substantial part of their working time outside a health facility, discharging their services at the individual, family or community level.” In practice, this definition was thought to be too narrow for practical purposes, because in many countries community-based services include those delivered from a local health facility, as illustrated in the Bangladesh example above. It was agreed to adapt the definition as follows:

“All services provided by people who spend a substantial part of their working time outside a health facility, discharging their services at the individual, family or community level, as well as primary health care services provided in small local health facilities. The exact boundaries of the definition will differ from country to country.”

### 3.2 Session 2: The future of community-based health care services, given changes in society, epidemiology and technology in South-East Asia

The second session discussed the future of community-based health services in the context of a fast-changing South-East Asia. The history of community-based services in South-East Asia is rooted in rural service provision focusing on maternal and child health and communicable diseases. The question asked was how relevant is this model for a region that now has more than half of its burden of diseases due to NCDs; almost half of its population living in cities; and high levels of mobile network coverage in many countries; (87% of the population of India, for example, lives where there is mobile network coverage).

Presentations from Sri Lanka, Kerala and Nepal reflected on the implications of changes in society, epidemiology and technology for community-based health services.

**Sri Lanka** has a very long history of community-based services, starting with the introduction of field public health midwives to Colombo Municipality in 1913. Public health midwives and public health inspectors are the main providers of community-based services. A variety of services –
such as MCH clinics, school medical inspections and community level screening clinics – are provided by multi-disciplinary teams, which include a medical officer as well as the public health midwife and inspector. In the last 100 years, there have been three unsuccessful attempts to integrate preventive and curative services, said Dr Sarath Amunugama in his presentation.

Sri Lanka has very specific plans in response to the rising rates of NCDs. The public health midwife will retain her role as the frontline worker providing community-based MCH care, but in future she will also work on promotive and preventive activities related to NCDs. With this expansion in her role, the average catchment population will be reduced from 3000 to 1500. Similarly, the public health inspector will have an enhanced role, including promotive and preventive activities related to NCDs and a reduced population to cover. To complement these changes, community-based outreach clinic screening for NCDs will be regularized and medical specialists will be encouraged to conduct clinics in PHC institutions, meaning that patients have less far to travel.

Another innovation in Sri Lanka is that a new cadre of community health nurse will be piloted in the near future. Working under the direction of medical specialists, these nurses will be based in hospitals and provide domiciliary care for people with NCDs. They will train family members on the care of patients with NCDs and follow up defaulters and treatment failures.
Dr K Ellangovan made the presentation on community-based health care services in Kerala, India, and stated that services are broad in scope and provided by a variety of health workers, as illustrated in Figure 3. Even so, community-based services in Kerala will need to adapt to an ageing population, as well as the availability of new information and communication technologies (ICT). A strong point was made that as the range of community-based services expands to include NCDs, development disorders, care of the elderly, palliative care and community mental health, care will need to be paid to careful role delineation for different cadres, so that services are provided without overlaps or gaps. Well-managed ICT can contribute significantly towards progress with UHC: for example, GIS facilitates detailed mapping of health needs and there are opportunities for field workers to retain and analyse their own local health data. There is an active eHealth programme in the state with the ultimate aim of a comprehensive health database of the population. This will have many uses, including informing resource allocation. Community-based health workers are central because they upload field-level data into the system. This feeling of “owning” local data and the greater understanding of community needs is expected to enhance community-based health workers’ confidence in responding to local needs.

*Figure 3: Community-based health care services in Kerala*

<table>
<thead>
<tr>
<th>Institutional service (Subcenter)</th>
<th>ANC Clinic, NCD, Drug distribution</th>
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<tr>
<td>Treatment services (Field Level)</td>
<td>Palliative care, DOTS, MDA</td>
</tr>
<tr>
<td>Maternal &amp; Child health</td>
<td>ANC, PNC, Immunization, FP services</td>
</tr>
<tr>
<td>Population health - Nutrition</td>
<td>ICDS, Iron &amp; Folic Acid, Vitamin A, Mid-day meal</td>
</tr>
<tr>
<td>Surveillance of Communicable diseases</td>
<td>Ward Level Sanitation &amp; Nutrition Committee, Syndromic surveillance, Case reporting</td>
</tr>
<tr>
<td>Social determinants of health</td>
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Services delivered by ASHA, junior public health nurse and junior health inspector

Courtesy: Dr K Ellangovan, India.
One problem identified in Kerala is that management of community-based services is currently piecemeal, and UHC will only be efficient if there is a holistic view of the services and good co-ordination between the various cadres.

The presentation made by Mr Sushil Baral from Nepal reflected on the opportunities and limitations of new technologies. Nepal is committed to both UHC and improving the quality of services. ICT is supporting these objectives in a variety of somewhat ad hoc ways including:

- The use of texting and mobile voice calls to communicate with female community health volunteers, many of whom are geographically very isolated.
- Training sessions provided remotely: much more affordable and uptake can be very high for a good quality session.
- The use of Facebook by health workers to seek advice about individual patients or to send information about outbreaks.
- Information about health and health services sent by SMS to individuals.

The presentation noted that there are good foundations to develop the use of ICT systematically in terms of political will and a growing number of users: this could bring substantial benefits given many isolated communities and difficult topography. The challenge now is to learn from the many pilots and to scale up the use of cost-effective technologies. Scaling-up will bring its own challenges:

- Not all policy-makers understand the potential benefits of greater ICT use.
- There is a risk of fragmented implementation.
- As well as procuring equipment and developing software, careful attention needs to be paid to capacity-building and procedures.
- Equity is difficult when power grid and network coverage varies geographically.
- High costs of new equipment, replacements and introduction of new technologies to health workers and managers.
As with many significant changes, the way in which the change is managed is crucial. The successful harnessing of ICT requires champions and focal points; developing adequate technical and management competency; scaling up with proper periodic evaluation; and considering sustainability. However, the potential benefits are great in terms of improving service provision.

The presentations from Sri Lanka, Kerala and Nepal about community-based health services in changing societies provoked considerable discussion, which was initiated by Dr Abdul Azeez Yoosuf from the Maldives. Three main threads emerged from the discussions.

- Once a new service is provided it can be difficult to withdraw, so it is important to know as much as possible about the likely impact of new services. **Pilots and phased scaling-up with evaluation** are useful approaches.

- There needs to be more **cost awareness** about community-based services. This has several dimensions, including for use in planning and for advocating about benefits of investing in cost-effective community-based services. Sometimes service change requires considerable up-front investment, even if the changes will pay for themselves in the long term (for example primary and secondary prevention of NCDs). It was noted that the intensification of community-based services in Sri Lanka was made possible by significant increases in health expenditure as a percentage of GDP.

- For both scaling-up and cost awareness, international evidence can be a starting point, but there is usually also a need for **country-specific information**.

It is not just technical aspects of community-based services that are changing: **the place of community-based services within the wider social system** is also subject to change. When alternatives are available – for example, private services that offer “desirable” treatments such as injections – communities may not be interested in using the government or volunteer community-based services. At the same time, if community health workers provide more services and develop closer links with the formal system, they may become less embedded in their own communities. Perceptions and
social position are important determinants of how services are accessed and their potential to be effective.

### 3.3 Session 3: Are different models of service delivery needed for difficult-to-reach and special population groups: remote areas; poor urban areas?

The background paper noted that when this topic was tabled for discussion by India, Bangladesh, Maldives and Sri Lanka, all had emphasized the importance of the topic in rural and hard-to-reach populations. The paper identified three important hard-to-reach groups: remote; poor urban; and a range of social groups that traditionally has limited contact with formal health services for a variety of reasons (e.g. migrants, commercial sex workers, injecting drug users). Technical Session 3 considered how models of community-based service provision may need to be adapted to suit the great variety in populations to be served.

Bearing in mind that UHC includes coverage for all hard-to-reach populations, participants heard presentations on Bhutan and Indonesia, as well as a contribution from the perspective of HIV programmes.

Mr Ugyen Dendup from Bhutan in his presentation stated that the country has around 1200 village health workers (VHWs – previously volunteer village health workers) who receive a 14-day initial training and 7-day refresher trainings. VHWs work in the areas of health promotion, disease prevention, informal counselling, social support, first aid and timely referrals. Curative services are generally provided in health facilities.

The VHW programme faces challenges in terms of VHW retention, no adequate supervision or monitoring, and financing. The Draft Programme Policy and Strategic Action Plan (2015–2020) seeks to strengthen the programme, aiming at 1 VHW for each of the 1044 Chiwogs (sub-blocks) in the country. VHWs will be introduced into urban areas and their motivation will be enhanced in a variety of ways including remuneration, Royal awards and the provision of a VHW kit and mobile vouchers. Efforts are being made to encourage more support for VHWs from both local government and traditional structures.
The key message from Bhutan was that even though the existing VHW programme had become rather demoralized and faced challenges, the role of VHWs was felt to be relevant and worth re-vitalizing, given the realities of health service coverage in Bhutan.

In Indonesia, community-based health care is provided through a number of initiatives including mandatory posting in a hard-to-reach area for doctors employed by the government; integrated health teams (including, among others, a doctor, nurse and lab technician) deployed to difficult areas and as part of a long tradition of community health volunteers linked to a variety of government, NGO and religious programmes. This information was presented by Dr Kumara Rai.

The main plank of Indonesia’s recent commitment to achieving UHC includes the expansion of mandatory social health insurance with a target of >95% insurance coverage by 2019. However, at a time when there is an ageing population with rising rates of chronic NCDs, there is paradoxically less emphasis on financing preventive and promotive measures in the social health insurance package. This raises an interesting question about financing of such services at the community level.

The final presentation in this session – by Dr Razia Pendse – focused on service delivery models for difficult-to-reach population groups based on the experience of HIV programmes. As shown in the table below, a broad range of HIV services can be based in the community. Over the years, a number of factors have combined to make community-based provision both desirable and feasible: high levels of activism from people living with HIV and AIDS; services were well funded; and the stigma associated with HIV meant that it was not always reasonable to expect a client to visit a conventionally managed health facility. This combination of circumstances means that there are a number of innovative models related to HIV services for hard-to-reach services: for example, peer support for vulnerable populations such as commercial sex workers and transgender people.
Figure 4: Community-led and community-based service delivery for HIV

<table>
<thead>
<tr>
<th>Prevention</th>
<th>HIV Testing</th>
<th>HIV treatment and care</th>
<th>Advocacy</th>
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<tr>
<td>HIV Testing and Counselling</td>
<td>Community-based testing</td>
<td>Treatment readiness</td>
<td>Access to services for marginalized communities</td>
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<td>Linkage to harm reduction services</td>
<td>Peer-led testing</td>
<td>Adherence</td>
<td>Access to affordable diagnostics and drugs</td>
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<tr>
<td>Health and psychosocial needs for risk reduction</td>
<td>Psychosocial support pre- and post-test</td>
<td>Retention in care</td>
<td>Reducing stigma and discrimination</td>
</tr>
<tr>
<td>Sexual and reproductive health issues</td>
<td>Disclosure of testing results</td>
<td>Nutritional support</td>
<td>Quality of service delivery</td>
</tr>
<tr>
<td>Condom distribution and counselling for consistent use</td>
<td>Follow-up for repeat testing</td>
<td>Treatment literacy</td>
<td>Access to ‘free’ services</td>
</tr>
<tr>
<td>STI diagnosis and referral for management</td>
<td>Contact/partner tracing, notification and support</td>
<td>ART maintenance</td>
<td>Legal support and advocacy</td>
</tr>
<tr>
<td>Pre-exposure Prophylaxis</td>
<td>Prevention of mother-to-child transmission</td>
<td>Peer support</td>
<td></td>
</tr>
<tr>
<td>Post-exposure Prophylaxis</td>
<td>Linkage to treatment, care and support</td>
<td>Community-based monitoring</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Follow-up for side effects</td>
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</tbody>
</table>

Courtesy: Dr Razia Narayan Pendse, WHO-SEARO.

Once again, a rich discussion followed the presentations, initiated by Mr Thomas Joseph from Bangalore, India. It was generally agreed that hard-to-reach populations are an enduring problem. The “shape” of community-based services will need to be as varied as the hard-to-reach populations themselves: for example, a stigmatized population may want a discrete service separate from where they live, whereas women whose mobility is restricted by social norms will need services very close to their homes. Governments are often not best-placed to develop services for hard-to-reach groups, and there should be openness to working in partnership, for example, with NGOs. Some of the challenges of community-based services in these circumstances were discussed: for example it can be difficult to identify suitable CHWs from some very marginalized populations that have had little access to education (and there must be flexibility with selection criteria) and sustainability can be a challenge because costs are often high and not funded from the mainstream budget.
The importance of monitoring was stressed: one important use of good indicators is to identify underserved hard-to-reach groups.

There was a particularly detailed discussion of community-based services for urban and peri-urban populations. In many instances, this has been neglected because of the belief that these groups are served by the private sector and will not use community-based services that they regard as inferior. There was a general interest in learning more about successful models for urban areas, as this requires a different approach, beyond the focus on geographical location. The experience of the United States was cited, where there are many community health workers working with particular groups according to language, disease or employment (for example, Spanish-speaking populations, families with a diabetic member and illegal migrant workers).

As in the previous session, participants also discussed the social position of community-based health workers and the way in which they were perceived by communities. Sometimes health workers themselves can be part of a problem with stigma and discrimination. A key part of community-based workers earning respect appears to be that they can provide effective links into the wider health system: if community-based services are only regarded as an inferior alternative to “better things”, they will not be used.

### 3.4 Session 4: Emergency preparedness as a part of community-based services

As explained in the Background Paper and the presentation made by Dr Roderico Ofrin, the issue of emergency preparedness is different from other community-based tasks because this is about preparing for another set of circumstances, rather than assessing how much can be achieved in a typical working day. A WHO SEARO meeting in 2010 recommended that ongoing training and orientation should be organized for community-based health workers (and other health personnel) in relation to emergencies, and Standard Operating Procedures developed (WHO SEARO 2010).

It takes time and money to prepare health workers for emergencies – and to ensure that they remain prepared. This is another issue that needs to
be considered in the context of strengthening community-based health services. The presentation on emergencies and ensuing discussion gave two clear messages in relation to community-based health services:

- As well as health skills, community-based health workers have important local knowledge about their communities that is critical in emergencies. They can help, for example, to identify who should receive certain supplies and services, such as specific drugs or items for infants.

- A good-quality basic training will serve well in an emergency. Some basic training in emergency preparedness can be a valuable addition to general training and should be targeted according to risk – e.g. focusing on the effects of floods in flood-prone areas.

New equipment often arrives after a disaster: community-based health workers are well placed to decide where best to locate the equipment. 
Courtesy: Dr Roderico Ofrin, WHO-SEARO.
3.5 Session 5: Looking forward: strengthening community-based services in the context of the post-2015 development agenda and universal health coverage

Session 5 was conducted in two parts. After all of the presentations were finished, time was taken on Day 2 of the meeting to bring together the main points from all the presentations, before discussing main messages and recommendations.

An important part of the discussion on Day 2 was to clarify the definition of “community-based health services”. This was needed because there was a tendency among all participants to focus on who was providing a service rather than on what services were being provided. However, the focus of the Regional Committee’s selected topic was community-based health care services.

Participants agreed that a systematic discussion of service delivery arrangements for increased coverage was an important part of universal health coverage, and complemented the current focus on health financing. It was noted that there is little work done on describing and analyzing the services provided at the community level as a whole and how well they fit together, even when provided by different health workers. Although it is conceptually more difficult to think about the services as a whole, it was agreed that it was important to do so. A useful approach is to regard “community” as a level of care, and to identify the broad package/range of services to be provided at that level before discussing which health workers (whether salaried or volunteer) will provide what services. The term “community-based health system” is one way of capturing the idea of looking at all services at that level. It was agreed that the “community-based health system” may or may not include a basic local health facility, depending on individual country arrangements. Each country can decide the exact boundaries depending on what makes operational sense.

Three other issues were discussed at some length in terms of emerging trends about community-based services:

- There is a growing range of services being provided at the community level, especially services related to NCDs. This raises a number of issues, including what levels of health worker can
be expected to safely provide which specific services, and how to maintain a reasonable balance between promotive, preventive and curative/disease management activities. The level and length of training must match the skills to be mastered and there needs to be a realistic assessment about referrals and the extent to which patients can access higher-level services.

- In many situations, there appears to be a trend to “regularize” the employment of voluntary (or quasi-voluntary) providers. “Regularization” involves becoming more institutionalized, i.e. a recognized part of the overall health system. This could include being eligible for a formally defined set of incentive payments or by being accredited for training in various modules. The training programme itself could also be accredited as a way of maintaining a focus on quality. There was much discussion about the pros and cons of regularization: on the one hand, it is a fairer and more realistic response to an increasing workload and enables a level of accountability; on the other, it may remove community health workers to some extent from the heart of their community and thus reduce local accountability.

- Different ways of organizing community services are clearly required for different types of communities. Most experience of specific outreach programmes and the deployment of CHWs come from rural areas; there was also awareness of a variety of models to reach specific social groups, such as commercial sex workers, and an understanding that NGOs are often best placed to develop services in these circumstances. In contrast, there seems to be a lot of work to do to understand how to increase coverage for various subpopulations in urban areas.

Discussion then moved on to considering what information is needed to improve community-based services. There are several different audiences for information, including parliamentarians, policy makers, operational planners and citizens, who need information about what services should be available and what is actually delivered (an aspect of social audit). The following points were made:
This is not only about needing more information: a good deal of data already exists, but is not always used or brought together in a useful way.

Community health worker programmes are often planned for, and managed, separately from plans for MOH technical programmes and facilities. This can mean that the value of community-based activities is not made clear to policy-makers and is not adequately reflected in national health strategies and plans. Doing a simple matrix mapping of the range of services to be provided by the various kinds of health workers at the community level would be useful for identifying overlaps and gaps in provision (this was also described as analyzing the “anatomy and physiology” of community-based services).

Some form of “scorecard” about community-based services might be useful in some countries to bring together what they are contributing to UHC in terms of access, coverage and the range and quality of services.

Very little appears to be known about the costs and cost-effectiveness of community-based services, in particular for full-scale programmes rather than small pilots.

Formal evaluation of different models for community-based services, and results obtained, would be useful. Models vary, for example, on the size of the catchment population for the lowest level of facility and on the balance between formally trained and community health workers.

The general discussion concluded with a reiteration of the overall conclusion: for UHC to succeed, it will be important to consider community-based services in their entirety, i.e. as a subsystem within the overall health system, and to respond strategically to challenges such as subpopulations with persistently low access, new diseases and the tendency to expect too much of volunteers (or quasi-volunteers) who have only received a very short training.
4. **Conclusion, Main Messages and Recommendations**

**Main messages from the Technical Consultation**

1. *With the transition from the MDGs to the SDGs, the commitment to universal health coverage, and the renewed emphasis on addressing inequalities, community-based services will continue to play an important role in future health systems.*

2. *It is important to look at community-based services as a whole—as a system or level of care within which a range of services are delivered, by a growing range of health workers from volunteers to salaried professionals. Community-based services are an important part of the wider health system, as well as being part of the community.*

3. *Community-based health services are a necessary part of advancing universal health coverage, because they can increase access to needed services especially for hard-to-reach groups. However, they are not always visible to decision-makers, especially at the national level.*

4. *The range of health services provided at the community level keeps changing and evolving, as health needs change. There is an increasing focus on noncommunicable diseases. These newer services are different from the more traditional ones covering MCH and communicable diseases, because they often require a circle of identification at the community level, referral for formal diagnosis and initiating treatment, and then follow-up at the community level.*

5. *To strengthen community-based health services, changes in the types of services provided need to be supported by changes in workforce training and supervision; medicines; financing; policies; legislation and access to new technologies. Developments in ICT are potentially very useful for community-based services, but scaling up small-scale ICT schemes is challenging.*
(6) In many situations, there appears to be a trend to “regularize” the employment of voluntary (or quasi-voluntary) providers. “Regularization” involves becoming a recognized part of the overall health system.

(7) Different approaches to community-based services are needed for different types of populations, for example, peri-urban communities, migrant workers, remote populations and socially marginalized groups.

(8) There are some information gaps about community-based health services, but more importantly a lot of information exists that is not used as well as it could be. Monitoring the full range of services would be useful, for example, through a ‘UHC scorecard’. Social audit has a role to play.

(9) There are some important evidence gaps. Evaluations of the different models developed in different countries and their impact on results would be useful. There is insufficient information about the costs and cost-effectiveness of community-based services.

(10) Community-based health workers of all types can play an important role in emergencies.

**Recommendations / Action Points**

**Recommendations for Member States**

(1) Ensure community-based health services are adequately reflected in national and subnational health strategies, plans and budgets.

(2) Develop emergency preparedness capacity in community-based health workers, whether formal health workers or voluntary community health workers.

(3) Synthesize existing information across community-based services as a whole, presented in ways that are easy for decision-makers to interpret.
(4) Consider ways to improve the national evidence base on different approaches to community-based service delivery, and their results, including how to ‘go to scale’ where appropriate.

**Recommendations for WHO**

(1) Develop a set of guiding principles for framing analyses of community-based health service delivery systems.

(2) Improve the regional evidence base: by encouraging national research on the impact of different models of community-based health services; by using tracer conditions such as diabetes to document approaches across a number of countries; by bringing together evidence from other regions – and present this in a way that is useful for SEAR countries.

(3) Encourage inclusion of community-based services in policy dialogue about UHC and support countries to ensure that community-based health services and systems are adequately reflected in new National Health Strategies.

(4) Support countries to further develop emergency preparedness in community-based health workers, whether formally trained or community health workers.
Annex 1

Background Paper –
WHO SEAR Technical Consultation –
Strengthening Community-based Health-care Services,
15–16 June 2015, WHO-SEARO, New Delhi, India

Background

Health in general – and universal health coverage (UHC) in particular – is an important element of the post-MDG development agenda. UHC requires that a reasonable range of services are available to all. Community-based services are clearly an important part of UHC because they enhance coverage and access, not only in terms of geography, but also affordability and acceptability.

It is thus fitting that “strengthening community-based health care services” was agreed at the Sixty-seventh Session of the Regional Committee as a topic for technical discussion. The aim of these discussions is to “enable WHO and Member States to re-orient and modify policies and strategies and appropriately plan”. This consultation is an opportunity to address questions about community-based services. This brief paper sets the scene for five sets of strategic questions, as summarized in the box below.

Conclusions and recommendations of this meeting will be presented to the Sixty-eighth Session of the Regional Committee in September 2015.

Box 1: Five sets of strategic questions about community-based health care services

| (1) | Is there sufficient descriptive information available about what is actually happening in terms of community-based services as a whole (the entirety of community-based services, rather than programme by programme)? If not, does this matter? Would it help to know more? If yes, in what way would better information about these services be useful? What kinds of decisions would it influence? |
Bearing in mind changes in society, technology and epidemiology, what should community-based services look like in five years’ time? What is the future for community health worker programmes? Do we need more formally trained health workers based in the community? What kinds of health workers? Where should limited resources be targeted?

Does it make sense to think of different models for the three main difficult-to-reach groups: remote; poor urban; and a range of social groups that traditionally have limited contact with formal health services (e.g. migrants, commercial sex workers, injecting drug users)?

Should emergency preparedness training be given to some or all community-based health workers? Which ones? How often?

There are clearly important strategic decisions to make about community-based services and the best way to work towards universal coverage that is also affordable, effective and safe. What needs to be done to help to inform these decisions about the future direction of service provision within communities and about who will provide these services?

Answers to these questions are the first step in strengthening community-based health care services.

The last Regional Committee report shows that a motivating factor for this proposal was that “India is polio free largely due to community-level services”. A vital aspect of community-level services was that community health workers (mostly accredited social health activists or ASHAs) could complement professional health workers who travelled out to communities in the following ways:

- Community health workers (CHWs) knew where people lived in their community and could locate children.
- CHWs were known to the community and parents trusted them when they recommended that children receive the polio vaccine.
- CHWs identified unserved communities such as migrant labourers.
- CHWs were reliable and accountable.

India’s proposal of the community-based health-care topic was approved by consensus. Bangladesh, Maldives and Sri Lanka all emphasized the importance of the topic in rural and hard-to-reach areas. This focus on accessible services is a topical reminder that UHC is about
more than financial protection and fits in well with other UHC-oriented initiatives, including emerging WHO work on people-centred and integrated health services and the South-East Asia regional decade of health workforce strengthening.

**What are community-based services and who provides them?**

*What are “community-based health care services”?*

The paper is not a comprehensive systematic review of the literature: its purpose is to identify strategic issues as a starting point for discussion. Nevertheless, it is necessary to mention the fact that definitions in the area of “community health services” are confusing: there is no consistent global usage. For the purpose of this discussion, community-based health care services means all services provided by people who spend a substantial part of their working time outside a health facility, discharging their services at the individual, family or community level.

The last page of this paper provide a set of definitions used in South-East Asia and comments briefly on the issue of inconsistent terminology.

*Who provides “community-based health care services”?*

Community-based health care services are provided by two distinct groups: by community health workers (who may or may not be volunteers) and by formally trained health professionals who focus on community work (they may be nurses, midwives, public health inspectors, family health visitors, doctors, etc.). The services can be run by government, NGOs or privately.

*A degree of consensus about community health workers (CHWs)*

The Alma Ata definition of “community health worker” is still widely used: CHWs should be “members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers”. Although there is great variety in the tasks performed by CHWs in different countries, they generally work in the areas of
Strengthening Community-Based Health Care Services

maternal, neonatal and child health and in communicable diseases. It is widely agreed that CHWs need to have strong links to the wider health system if they are to be effective: these links include adequate clinical and managerial support; regular supplies; and the possibility to make a referral to see a health professional, with a reasonable likelihood that the patient will actually be able to access that professional.

The 2011 session of the WHO Regional Committee for South-East Asia discussed *Strengthening of the community-based health workforce*. The discussion focussed on CHWs and concluded that they can contribute to improving access, coverage and health outcomes. CHWs should be viewed as an integral part of the health system, with well-defined roles; CHW programmes should be adequately funded and should not be seen as cheap alternatives to “proper” care. The discussion noted that CHW programmes will need to adapt to fast-moving changes in the South-East Asian society – this issue is expanded below.

**CHWs’ role in service provision: moving in different directions in different countries**

There may be broad agreement about the definition of CHW and what is needed for them to be effective, but there is great variety in what is actually happening with CHW programmes in South-East Asia:

- Nepal has a long-standing network of CHWs and is currently focusing on expanding their role in relation to maternal, neonatal and child health.

- In India, ASHAs (accredited social health activists) are a relatively new cadre and there are already plans to extend their role to include noncommunicable diseases (NCDs).

- In Sri Lanka, deliveries are now overwhelmingly conducted in health facilities, meaning that the balance of community-based activities has changed. In addition to “traditional” activities such as antenatal support, there is a growing focus on NCDs, palliative care, alcohol abuse, suicide and violence.

- In Bangladesh, rather differently, the current emphasis is on the importance of investing in community clinics to complement and support the work of CHWs. Issues debated in recent years
in Bangladesh have been on whether CHW programmes are close to reaching the limits of what they can reasonably achieve (given their skill sets and status as volunteers) and whether their ongoing work is better complemented by very local community clinics or by more distant, better-resourced, facilities.

A range of community services provided in a variety of ways by formally trained health workers

In contrast to the sizeable literature about CHWs, much less is written about the formally trained health workers who spend a substantial portion of their time working in the community. They are not generally discussed as a group: indeed it is not really clear what to call them collectively. However, it seems reasonable to hypothesize that most of the work done by formally trained community-focused health workers comes under at least one of the following categories:

- eradication (e.g. polio)
- major infectious disease (e.g. HIV, TB)
- very high national (or global, or regional) priority (e.g. pregnancy/newborn, family planning, immunization)

These three categories are all areas where there is an interest in having very high levels of coverage. For health issues that do not come under any of these categories, people are expected to take the initiative themselves and find their way to a health facility.

Formally trained community health workers clearly operate in a variety of ways:

- Travelling relatively large distances to perform specific tasks. These mobile services tend to be rather specialized, though there are many examples of teams being formed to provide a range of services. For example, the WHO document Sustainable Outreach Services discusses how to reach unimmunized rural populations with a variety of services. In addition to immunization and Vitamin A, services which might also be included were in relation to malaria, scabies, soil-transmitted helminth infections, schistosomiasis, iodine and iron
supplementation, lymphatic filariasis, guinea worm eradication, environmental management for disease vector control and onchocerciasis (WHO, 2000). In situations where international aid is significant, there can be an issue around the sustainability of these types of mobile services, as they are often started with donor funds.

- Working in a smaller area in a broader way (for example, MCH nurses who do work related to pregnancy, family planning, immunization, childhood illnesses, etc.).
- Serving in a population-based role (rather than individual clients), for example, health inspectors dealing with sanitation and food hygiene.

There is also a hybrid type of health worker who spends most of their time working in a health facility but who travels to a community maybe once a week to provide various outreach services.

Good descriptions of the totality of services provided by this mix of formally trained health workers and CHWs would inform a number of important strategic issues such as whether or not community-based services as a whole provide all the most cost-effective, priority interventions, or whether opportunities are missed to make provision more efficient. Another strategic concern is the extent to which the works of formally trained health workers send out a consistent message to CHWs about what is expected of them and what they should be prioritizing.

Is this lack of information about community-based services as a whole a real problem, or an artificial “academic” one? The first set of questions aims to address this issue.

**Set of questions #1**

Do we know enough about what is actually happening in terms of community-based services as a whole (the entirety of community-based services, rather than programme by programme)? Does this matter: would it help to know more? If yes, in what way would better information about these services be useful? What kinds of decisions would it influence?
**South-East Asia is changing fast.……….**

South-East Asia is changing fast: a few examples of these changes are given in the box below. Do changes in society, epidemiology and technology mean that we should be thinking differently about community-based health services in the future?

**Box 2: The changing face of South-East Asia**

- The population is *ageing* as shown in these regional population pyramids.

- The *urban* population of South-East Asia more than doubled between 1990 and 2014. The proportion of people who live in an urban area is now 49% and is increasing by 1.5% per year. (UN Department of Economic and Social Affairs)

- Since 2000, the percentage of *births attended by skilled health personnel* has risen from 45% to 68%.

- Of all the WHO Regions, South-East Asia has the highest age standardized *NCD (noncommunicable diseases) mortality rate* (over 650 NCD deaths per 100,000 population, all ages).

- 87% of the population of India (as an example) lives where there is *mobile network coverage*; there are 762 million active mobile connections.

**Changes in epidemiology**

South-East Asia faces significant challenges in terms of communicable diseases and maternal and child health. However their *relative* importance is decreasing as people live longer and rates of NCDs rise. There is growing recognition of the huge unmet need in the field of mental health. These new issues (ageing, NCDs and mental health) are different from the current focus of community-based work (MNCH and communicable diseases) in the following ways:
The priority is not to reach every single person (NCDs and mental illness are not communicable and cannot be eradicated): the focus is on the needs of a significant number of people with chronic problems (and intermittent health crises).

There is less chance that NCDs or mental health will attract the high-level political attention that eradication and life-saving actions do (although specific issues may be the exception, for example, cervical cancer or suicide).

Important aspects of the well-being of people with NCDs or mental disorders are the individual’s life-style, their home circumstances and the wider environment of social support.

There are many reasons not to institutionalize long-term chronically ill people, so alternatives such as self-care, home-care, carers, etc. need to be developed.

Managing NCDs is different because it involves screening people who feel well.

The box below describes in more detail some of the community-based interventions for mental health and NCDs.

**Box 3: Community-based activities for NCDs and mental health**

WHO has produced a global guide for mental disorders in nonspecialized health settings, based on “the reality ....that most of the mental, neurological and substance use conditions that result in high morbidity and mortality can be managed by non-specialist health-care providers.” (WHO, 2010a) The Guide identifies some general principles about mental health care. About half of these principles are actions that are appropriately carried out in the community, rather than in a health facility. These include:

- Where appropriate and with the person’s consent, help family members and other carers to understand the condition and how best to care for the person (including adherence to treatment and follow-up appointments).
- Maximize the ways in which the person is supported by, and involved with, their community.
- Be alert to social challenges and changes that the person may face and understand how these may affect their mental health.
- Link in to groups that support self-help, carers, home-based care etc.
- Encourage the person to look after their physical health, including in relation to diet, alcohol and smoking.
Vital elements of the management of NCDs include:

- Persuading people to change their behaviour in relation to physical exercise, diet, alcohol and smoking (for primary and secondary prevention). To be effective this may involve working with other family members too – for example, the person who does most of the cooking in a household.
- Targeted screening.
- Support for adherence to treatments (e.g. management of diabetes). (WHO 2010b)

Alongside this epidemiological transformation are broader changes. South-East Asia is becoming richer and more urbanized; many people have better access to government health facilities and a greater choice of alternative providers in the private sector. These changes will inevitably influence both the recruitment of, and attitudes to, volunteer health workers.

The pace of change raises questions about the future look of community-based health services. How effective can CHWs be in the face of NCDs and mental health disorders? Or do we need a greater community presence of formally trained health workers, either because of the level of skill required or because it is not appropriate to ask volunteers to do these kinds of job? Do the same answers apply to both rural and urban areas?

Changes in technology

Access to mobile technology is growing fast. As mentioned above, India has 87% of its population living where there is mobile network coverage and has 762 million active mobile connections. Given that this picture is replicated across much of South-East Asia, is the technology being fully exploited? What are the estimated rates for SIM subscription by community-based health workers?

Definition of mHealth

WHO defines mHealth as “a medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices”. (WHO, 2011)
mHealth – the use of mobile devices such as mobile phones – offers a wide range of new opportunities for community-based health services. Table 2 lists some of the main uses. Each can apply to almost any type of service – TB, malaria, HIV/AIDS, MNCH, noncommunicable diseases, etc. Some uses are about new tasks, others are about performing existing tasks more efficiently and effectively. A vivid example of “this is not new” comes from lessons learnt from the guinea worm eradication effort. One key success factor was the monthly reporting from a network of village volunteers: this scheme was set up specifically for guinea worm eradication and provided vital evidence to programme staff. The point here is that village-based reporting is not new: what is different now is the potential to do this more cheaply and quickly using mobile technologies. (Hopkins)

mHealth has the potential to make a big difference to community-based health care. While the location may be remote, there can be daily interaction with other health workers; information such as diagnosis and treatment protocols can be stored on one hand-held device; and health information can be transmitted through user-friendly applications in real time from the same device. Stocks can be monitored centrally and (in theory at least) replenishments can be sent out in good time. Some mobile devices can also measure a patient’s temperature, rate of breathing, etc.  

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1 The variety of mHealth activities in South-East Asia is demonstrated by:

- USAID’s Integrating Mobiles into Development Projects (2014), which lists mhealth platforms (mobile applications or services) currently used in South-East Asia and USAID-funded projects that use mobile applications in the region.
- The National Health Portal (NHP) of India, which lists apps and software in use in the Indian health sector. Examples include a Safe Pregnancy and Birth app that includes instructions for CHWs; and the Geochat-Collaboration tool mobile app that allows chatting, reporting and receiving alerts.
Table 1: Uses of mobile devices (adapted from Labrique et al.)

<table>
<thead>
<tr>
<th>Potential uses of mobile devices</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Client education and behaviour change communication</td>
<td>Mobile messaging for client groups (e.g. for pregnant women). Apps to support education sessions on smoking cessation.</td>
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<tr>
<td>Point-of-care diagnostics</td>
<td>HIV: use of mobile phone to interpret CD4 count readings</td>
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<tr>
<td>Registries/vital events tracking</td>
<td>MomConnect is used in South Africa to enhance a national registry of pregnancies</td>
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<tr>
<td>Data collection and reporting</td>
<td>Household surveys conducted with tablets and data uploaded in real time</td>
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<tr>
<td>Electronic health records</td>
<td>An App in Australia tells parents about their child’s immunization status and reminds them when a vaccination is due</td>
</tr>
<tr>
<td>Electronic decision support</td>
<td>System to assist CHWs with the follow-up and management of high-risk cardiovascular patients (Ajay); thousands of Apps related to diabetes</td>
</tr>
<tr>
<td>Provider-to-provider communication</td>
<td>E-referrals to hospitals for advice when patient travel not possible</td>
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<tr>
<td>Provider work-planning and scheduling</td>
<td>Scheduling of ante-natal appointments</td>
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<tr>
<td>Provider training and education</td>
<td>Voice messages to CHWs with reminders of key health promotion messages and relevant updates</td>
</tr>
<tr>
<td>Human resource management</td>
<td>Supervisors can regularly phone their supervisees, even when distances are large and face-to-face meetings difficult to arrange</td>
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<tr>
<td>Supply chain management</td>
<td>Alerts about stock-outs; identification of counterfeit drug packaging</td>
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<tr>
<td>Financial transactions and incentives</td>
<td>Transferring credit for incentive payments or to enable CHWs to use their mobile phones</td>
</tr>
<tr>
<td>Hotlines or call centres</td>
<td>Hotlines enable clients to directly consult health professionals, sometimes 24 hours per day</td>
</tr>
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</table>
A systematic review of the literature on CHWs and mobile technology was conducted in 2013 (Braun). This concluded that in the right conditions, CHWs find the technology acceptable and usable and it can improve reporting, help decision-making and enable more clients to be served. Not surprisingly, there are challenges related to battery life, network availability/phone coverage and maintenance. Some support measures are known to help, such as a help-line for users.

The rapid pace of change in mHealth poses challenges for ministries of health. For example, the inSCALE Project observed in 2012 that “When working within a field that has a lot of momentum, the “crowding” of organisations working in this field - sometimes with competing/similar objectives – can lead to challenges in getting buy-in and support from Ministries of Health to all project activities.” inSCALE gave the example of the proliferation of mHealth pilots in Uganda, where more than 60 projects were running simultaneously with little involvement of the Ministry of Health. It took time for a government-led process to get underway so that projects could be coordinated and government priorities addressed. In 2012, the Ugandan Ministry of Health imposed a moratorium on all mHealth projects and developed an eHealth policy (including mHealth). If governments are to be convinced about timely investments in mHealth, they need to be involved in innovations – arrangements such as national and local steering committees can be helpful. (Malaria Consortium)

The situation for medical technology is in some ways the same as, and related to, developments with mobile devices. There are numerous innovations in technologies to diagnose and treat diseases at the point-of-care for people living in rural and urban low-resource settings. For example, there are rapid diagnostic tests available for malaria and pneumonia that can extend the availability of good-quality treatment, but these tests are not as widely available as they could be.²

Changes in technology raise a number of questions for ministries of health in relation to community-based programmes. How are ministries responding to changes in technology? Do they have staff who sufficiently understands these issues? Are ministries actively seeking technological solutions to problems they face, or are developments driven by technology experts? Are there eHealth policies? Are there interest groups or policies

² For example, the PATH website describes innovations in technologies to diagnose and treat diseases at the point-of-care for people living in rural and urban low-resource settings (http://sites.path.org/dx/).
and regulations that delay change, such as rules about who can administer what clinical tests or when paper-based documentation is needed?

Taken together, changes in epidemiology, society and technology have prompted the second and third sets of questions about strategic issues related to community-based services.

<table>
<thead>
<tr>
<th>Sets of questions #2 and #3</th>
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<tbody>
<tr>
<td>Bearing in mind changes in society, technology and epidemiology, what should community-based services look like in five years’ time? What is the future for CHW programmes? Do we need more formally trained health workers based in the community? What kinds of health workers? Where should limited resources be targeted?</td>
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</table>

Does it make sense to think of different models for the three main difficult-to-reach groups: remote; poor urban; and a range of social groups that traditionally have limited contact with formal health services for a variety of reasons (e.g. migrants, commercial sex workers, injecting drug users)?

**Emergencies and disasters**

The issue of emergency preparedness is clearly different from other community-based tasks because this is about preparing for another set of circumstances, rather than assessing how much can be achieved in a typical working day. A WHO SEARO meeting in 2010 recommended that ongoing training and orientation should be organized for community-based health workers (and other health personnel) in relation to emergencies. Moreover, Standard Operating Procedures should be developed so that different cadres know what would be expected of them. (WHO SEARO 2010)

As an illustration of the issues, CHWs played a key role following Typhoon Haiyan in the Philippines in 2013. However, more preparedness training would have enabled them to do a better job. One issue was that the roles and responsibilities of various groups were not clear, so that CHWs were removed from health-focused work to do activities such as supporting relief teams with their logistical and administrative needs, assisting with relief material distribution and collecting household information on shelter and damages. While all these jobs are important – and CHWs could do them – the point is that others could also have done this work. Another issue was that CHWs felt overwhelmed by the injuries they were faced with and did not have strategies for prioritizing their work: it is of course natural to feel overwhelmed, but training in advance could
have helped to alleviate the situation and enable CHWs to be as productive as possible under the circumstances.

It takes time and money to prepare health workers for emergencies – and to ensure that they remain prepared. This is another issue that needs to be considered in the context of strengthening community-based health services. This leads to the fourth set of questions.

Set of questions #4

Should emergency training be given to some or all community-based health workers? Which ones? How often?

Strategic issues in strengthening community-based health care services

This paper raises many questions about community-based health services. This final section suggests two simple devices – a table and some pie charts – to stimulate discussion around the five sets of questions given on page 1.

What services should be provided at the community level? How should the interventions be prioritized, given changing disease patterns and the interest of so many health programmes in having a community presence? The idea of Table 2 is to stimulate discussion about who should be doing what (CHWs, formally trained community health workers or PHC facility staff) in a particular country/locality. The first column lists types of work that could be provided in the community; the next four columns are the four broad categories of burden of disease (MNCH, communicable, noncommunicable, mental health). The table can be completed in a number of ways, for example, by putting HF (health facility), CHW (community health worker) or FTHW (formally trained health worker) or “no service” in each box and doing this twice, once for what currently happens and once for what should be happening in five years’ time.

Filling in the table gives rise to a number of strategic questions, including:

- Does the current situation match the burden of disease in the country/locality? If not, why not? What should be done about this? How should changes be made and at what speed?
- Given the number of boxes ticked, is one CHW per community enough? How can the workload best be managed? What does
the exercise tell you about the need for more formal training of health workers for the community?

- Are CHWs regarded as a “permanent” feature of the health system, or are they a temporary measure until more qualified health professionals are available? For example in mental health, would the role of CHWs be reduced dramatically if there were many more qualified mental health workers?3

- Should the answers for urban and rural CHWs be different? What about CHWs located in extremely remote places? What are the implications of this for the overall CHW Programme Strategy?

Table 2: Who should provide the following types of services (facility-based staff, trained health workers in the community, CHWs)? Now? In five years’ time?

<table>
<thead>
<tr>
<th>Types of services provided in the community</th>
<th>MNCH &amp; minor ailments</th>
<th>Communicable diseases</th>
<th>Non-communicable diseases</th>
<th>Mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment in a one-stop shop</td>
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<tr>
<td>Prevention (face-to-face behaviour change)</td>
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<tr>
<td>Prevention (community actions)</td>
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<tr>
<td>Identify and refer patients, if possible informed by screening or diagnosis</td>
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<tr>
<td>Support patients to adhere to treatments prescribed in health facilities</td>
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</table>

SEAR disease burden 35% MNCH & Communicable Diseases and 53% NCD and mental health (MH) – 2012 Global burden of disease study – and the trend is increasing NCD and MH disease burden

In an article about schizophrenia, Chatterjee et al (2014) argue that CHWs can be allocated roles that in future would be better performed by a health professional and that CHWs can achieve relatively little in the absence of links to professional staff. They argue that CHWs may well have a long-term role in mental health, but that the nature of their involvement will change radically if and when more professional mental health staff are posted throughout a country.

3
<table>
<thead>
<tr>
<th>Types of services provided in the community</th>
<th>MNCH &amp; minor ailments</th>
<th>Communicable diseases</th>
<th>Non-communicable diseases</th>
<th>Mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit homes (either all homes or for target groups such as newborns)</td>
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<tr>
<td>Chronic care: support people after they have received a diagnosis (e.g. how best to look after themselves, providing care in their homes)</td>
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<tr>
<td>Support carers</td>
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<tr>
<td>Increase actual access/utilization by being a trusted provider when no other exists (e.g. for specific groups such as commercial sex workers or injecting drug users)</td>
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<tr>
<td>Provide information/data “up” the system for use in decision-making</td>
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<tr>
<td>Be a trusted intermediary who knows where people live and can introduce visiting health professionals (e.g. for eradication efforts or contact tracing)</td>
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<tr>
<td>Providing services in areas where government cannot have an effective presence (e.g. because of conflict)</td>
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<tr>
<td>Surveillance</td>
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<tr>
<td>Training in emergency preparedness for all health workers?</td>
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</table>
How to allocate additional resources?

Community-based health services are provided by CHWs and formally trained health workers, with vital support from PHC facilities. The pie charts below represent three possible scenarios for additional spending on primary health care facilities (blue), formally trained health workers (green) and CHWs (red). Where does the priority lie in your country? Is the main need now to strengthen PHC facilities so that they can provide a range of good-quality services? Or should the focus be on CHWs, as they represent the best value for money? Or maybe all three areas need to expand together? How would you divide out an additional $x million?

In the three illustrations, scenario 1 prioritizes strengthening PHC facilities. The view here may be that facilities need to be able to deal with diagnosing and treating NCDs and mental health, for example, before more illness occur in the community. The third scenario, in contrast, would spend most on strengthening CHW programmes. In order to strengthen community-based services as a whole, how would you divide out the pie?

The fifth and final overall question relates to the regional discussion about community-based services and what can usefully be done from a regional perspective.

Question #5

There are clearly important strategic decisions to make about community-based services and the best way to work towards a universal service that is also affordable, effective and safe. What needs to be done to help inform on decisions regarding the future direction of service provision within communities and who will provide these services?
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Definitions related to “community-based health services”

Definitions in the area of “community health services” are confusing: there is no consistent global usage. In the global literature, the terms “community-based health care services” and “community health services” are not used frequently or consistently in the context of low- and middle-income countries. When the terms are used, they tend to refer to formal, facility-based services and are often a synonym for “primary care facility.” The literature on “community health services” is mostly from high-income countries and deals with health professionals who work within communities, such as community nurses and midwives. There is more agreement about the definition of “community health worker,” with the Alma Ata definition (given below) still widely used.

For the purposes of this paper, community-based health care services has been defined as all services provided by people who spend a substantial part of their working time outside a health facility, discharging their services at the individual, family or community level. Community-based healthcare services are provided by two distinct groups: community health workers (who may or may not be volunteers) and formally trained health professionals who focus on community work (they may be nurses, midwives, public health inspectors, family health visitors, doctors, etc.).

The following definitions were used in the WHO SEARO Working Paper (2011) to describe the community-based health workforce.

Community-based health workers (CBHW): All health care workers who are part of the formal health organization, and have undergone formal training to carry out a series of specified roles and functions, and spend a substantial part of their working time actively reaching out to the community, discharging their services at the individual, family or community level. These may include doctors, nurse and, midwives who fulfill the above criteria; public health inspectors; health attendants; health supervisors; and family health visitors, etc. who spend a substantial part of their working time actively reaching out to the community.
Alma Ata definition: Community health workers (CHWs) should be members of the communities where they work; be selected by the communities; be answerable to the communities for their activities; be supported by the health system but not necessarily a part of its organization; and have shorter training than professional workers.

Community health volunteers (CHV): Members from communities often selected by the communities themselves and answerable to them, and who have undergone shorter training than professional workers. They are not salaried but may receive financial and other incentives. They are predominantly involved in health promotion and prevention of health problems, and are supported by the community and health system but are not necessarily a part of the formal organization.
Annex 2

Programme –
WHO SEAR Technical Consultation –
Strengthening Community-based Health-care Services,
15–16 June 2015, WHO-SEARO, New Delhi, India

Day 1-Monday, 15 June 2015

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>0800 - 0830</td>
<td>Registration</td>
</tr>
</tbody>
</table>
| 0830 - 0930 | **Session 1: Introduction**  
Opening Remarks  
Dr Poonam Khetrapal Singh, Regional Director, South-East Asia Region of WHO  
Objectives of the meeting and scene-setting for the consultation  
Dr Phyllida Travis, Director, Health Systems Development, WHO/SEARO  
Introduction of participants and administrative announcements  
Dr Sunil Senanayake, Regional Adviser, Health Systems Management, WHO/SEARO |
| 1000 - 1130 | **Session 2: What are community-based health care services and who currently provides them? How much information do we have on overall patterns and trends? How is this being used by decision makers?**  
**Introduction**  
Dr Catriona Waddington, consultant  
The role of the ASHA in Community-based health services in India  
Dr Rajani Ved, Advisor Community Processes, National Health Systems Resource Centre (NHSRC), New Delhi.  
Community clinics in Bangladesh, as a strategy for expanding access to care: lessons learned  
Dr Liaquat Ali Khan, Programme Manager, Revitalization of Community Health Care Initiative, MOH Bangladesh |
<table>
<thead>
<tr>
<th>Time</th>
<th>Session 3, Part 1: The future of community based health care services, giving changes in society, epidemiology and technology in South-East Asia</th>
</tr>
</thead>
</table>
| 1130 - 1300 | | Introduction Dr Catriona Waddington  
Perspectives on the future of community-based health care services in Sri Lanka  
Dr Sarath Amunugama, Deputy Director General (Public Health Services) MOH, Sri Lanka  
Perspectives on the future of community-based health care services in Kerala  
Dr K Ellangovan, Health Secretary, Government of Kerala, India  
Opportunities and limitations of new technologies: some reflections  
Mr Sushil Chandra Baral, Executive Director Health Research and Social Development Forum, Nepal  
Discussant: Dr Abdul Azeez Yoosuf, Senior Consultant in Medicine, the Maldives  
Plenary discussion, mainly focused on question 2 of the background paper |
| 1400 - 1530 | Session 3, part 2: The future of community based health care services, giving changes in society, epidemiology and technology in South-East Asia  
Are different models of service delivery needed for difficult-to-reach population groups: remote areas; poor urban areas; special population groups?  
Introduction Dr Catriona Waddington  
Perspectives from Bhutan Mr Ugyen Dendup, Sr. Program Officer, Village Health Worker Programme, MOH, Bhutan  
Perspectives from Indonesia Ms Muhani, SKM, MKM, Head of Finance Subdivision, General Affair Division, Centre for Health Promotion, Secretariat General, MOH, Indonesia & Dr Nyoman Kumara Rai, Former Adviser to RD-SEARO |
<table>
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<tr>
<th>Time</th>
<th>Session/Activity</th>
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<tbody>
<tr>
<td>0830-0945</td>
<td><strong>Framing The Way Forward</strong></td>
</tr>
<tr>
<td>1000-1230</td>
<td>Session 4: Emergency preparedness as a part of community-based services: lessons from Nepal earthquake and Tsunami experience</td>
</tr>
<tr>
<td>1330-1430</td>
<td>Part 1: What are the main issues arising so far? Plenary discussion, based on question 4 of the background paper</td>
</tr>
<tr>
<td>1445-1630</td>
<td>Session 6: Way forward: conclusions and recommendations Agreement on main messages, conclusions and recommendations to the Regional Committee</td>
</tr>
<tr>
<td>1630</td>
<td>Closing remarks</td>
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</table>

**Day 2- Tuesday, 16 June 2015**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session/Activity</th>
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<tbody>
<tr>
<td>0830-0945</td>
<td><strong>Framing The Way Forward</strong> Day 2 Co-chairs: Dr K Ellangovan, Health Secretary, Government of Kerala and Dr Sarath Amunugama, Deputy Director General, Ministry of Health, Sri Lanka</td>
</tr>
<tr>
<td>1000-1230</td>
<td>Session 5: Looking forward: strengthening community-based services in the context of the post 2015 development agenda and Universal Health Coverage Part 1: What are the main issues arising so far? Overview: Dr Phyllida Travis Plenary Discussion</td>
</tr>
<tr>
<td>1330-1430</td>
<td>Session 5: Looking forward: strengthening community-based services in the context of the post 2015 development agenda and Universal Health Coverage Part 2: Emerging messages Plenary Discussion</td>
</tr>
<tr>
<td>1445-1630</td>
<td>Session 6: Way forward: conclusions and recommendations Agreement on main messages, conclusions and recommendations to the Regional Committee</td>
</tr>
<tr>
<td>1630</td>
<td>Closing remarks</td>
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</table>

**Perspectives from HIV** Dr Razia Pendse, Regional Adviser HIV/AIDS & STI

**Discussant:** Mr Thomas Joseph, Consultant, Bangalore, India

Plenary discussion, mainly focused on question 3 of the background paper

1600 – 1700 | Group work: information and evidence on the current situation

1700 | Quick recap of day 1 and outline of objectives and programme for day 2
Annex 3

List of participants –
WHO SEAR Technical Consultation –
Strengthening Community-based Health-care Services,
15–16 June 2015, WHO-SEARO, New Delhi, India

Bangladesh

Dr Liaquat Ali Khan
Programme Manager
Revitalization of Community Health Care Initiatives in Bangladesh (RCHCIB) Project
BMRC Bhaban, Mohakhali
Dhaka

Bhutan

Mr Ugyen Dendup
Program Officer
Village Health Worker Programme
Department of Public Health
Thimpu

India

Dr K. Ellangovan
Health Secretary
Government of Kerala
Kerala

Capt. (Ms) Kapil Chaudhary
Deputy Secretary
Ministry of Health & Family Welfare
New Delhi

Dr Rajani Ved
Advisor Community Processes
National Health Systems Resource Centre (NHSRC)
New Delhi

Maldives

Mr Nayaz Ahmed
Director
Dhamanaveshi / Health Protection Agency
Male, Republic of Maldives

Sri Lanka

Dr Sarath Amunugama
Deputy Director General (Public Health Service)
Ministry of Health
Colombo

Thailand

Dr Suchart Laobhripatr
Director
International Health Division
Department of Health Service Support
Ministry of Public Health
Nonthaburi

Timor-Leste

Ms Isabel Maria Gomes
Director of Community Health Services
Ministry of Health
Democratic Republic of Timor-Leste
Dili

Technical Experts

Dr Abdul Azeez Yoosuf
Senior Consultant in Medicine
Maya Clinic, AMDC Medical Center
Male’
Republic of Maldives
Strengthening Community-Based Health Care Services

Dr Himangi Bhardwaj  
Senior Health Adviser  
British High Commission  
New Delhi, India

Dr Nyoman Kumara Rai  
Former Adviser to RD-SEARO  
Bali, Indonesia

Dr Palitha Abeykoon  
Chairman  
National Authority on Tobacco & Alcohol (NATA) and Advisor  
Ministry of Health  
Colombo, Sri Lanka

Dr Sanjay Chaturvedi  
Professor and Head  
Department of Community Medicine  
University College of Medical Sciences  
Delhi, India

Dr Sushil Chandra Baral  
Executive Director  
Health Research and Social Development Forum (HERD)  
Thapathali, Kathmandu  
Nepal

Mr Thomas Joseph  
Consultant (Independent)  
Bangalore, India

Dr Catriona Waddington  
Consultant  
Mott Macdonald Limited  
Mott Macdonald House  
London, U.K.

SEARO / WHO Country Office

Dr Chandrakant Lahariya  
National Professional Officer  
Universal Health Coverage  
WCO India

Mr Daniel Ernesto Albrecht Alba  
Technical Officer (TO)  
WCO India

Dr Francisco Katayama  
Technical Officer  
Partnerships, Interagency Coordination and Resource Mobilization (TO-PIR)  
WHO SEARO

Dr Kathleen Anne Holloway  
Regional Adviser  
Essential Drugs & Other Medicines (RA-EDM)  
WHO SEARO

Dr Kwang Rim  
Medical Officer  
Tuberculosis Unit (MO-TUB)  
WHO SEARO

Dr Neena Raina  
Regional Advisor  
Child and Adolescent Health (RA-CAH)  
WHO SEARO

Dr Pak Tong Chol  
Regional Advisor  
Human Resource for Health (RA-HRH)  
WHO-SEARO

Dr Rajesh Pandav  
WHO Representative to Timor-Leste

Dr Razia Narayan Pendse  
Regional Adviser  
HIV/AIDS & STI (RA- HIV/AIDS & STI)  
WHO SEARO

Dr Rajesh Mehta  
Medical Officer  
Child and Adolescent Health (MO-CAH)  
WHO SEARO
Dr Roderico Ofrin  
Coordinator, Emergency and Humanitarian Action (EHA)  
Acting Director, Health Security and Emergency Response (HSE)  
WHO SEARO

WHO Secretariat (SEARO)

Dr Phyllida Travis  
Director  
Department of Health Systems (HSD)  
WHO SEARO

Dr Sunil Senanayake  
Regional Advisor  
Health Systems Management (RA-HSM)  
WHO SEARO

Ms Purvi Paliwal  
Technical Officer  
Health Economics and Health Planning (TO-HEP)  
WHO SEARO
Annex 4

Opening address – Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region

Distinguished participants, Ladies and Gentlemen,

I would like to extend a very warm welcome to all of you.

It is my great pleasure to open this important meeting. At every Regional Committee Meeting, a technical subject is chosen for detailed discussion at the next RC. And the 2014 RC agreed that the subject of this year’s technical discussion would be community-based health care services. It was proposed by India and supported by Bangladesh, Maldives, and Sri Lanka.

There was a technical discussion on a related topic of community health workers in 2011. This year’s discussion will build on that, not repeat it. It will focus on non-facility-based services, and on community-based service delivery rather than community engagement more generally, though this will inevitably come in as part of discussions.

2015 marks the transition from the Millennium Development Goals or MDGs to the Sustainable Development Goals or SDGs. The targets for the SDG health goal include Universal Health Coverage, which is an important priority subject for all SEAR Member States. UHC is about increasing all people’s access to care that they need, and about protecting them from being impoverished as a result of health care. It includes a fundamental concern with reducing inequities in access to care. Community-based health care services are an essential link in the service delivery chain for many health priorities.

Ladies and Gentlemen,

Following the Alma Ata Declaration on Primary Health Care in 1978, the countries of this Region have done a lot of good work on community-based health services; several countries still have excellent community-based health care service programmes in place.
I understand that this consultation will draw on a range of experience to analyse the ‘ingredients’ of successful community-based services: what has worked and not worked, and why?

I hope that this meeting will provide an opportunity to hear of the experiences from different countries and capture the lessons learnt for shaping future community-based health care service delivery in our Region. Although there are many success stories, there is very little documentation of it. I hope that this meeting will, to some extent, fill that gap.

I see that you have before you a comprehensive agenda for the next two days to discuss and share experiences from countries of our Region and beyond. Although the meeting duration is short, I am pleased that you have gathered here a host of people who bring tremendous experience and knowledge on this matter and, therefore, I have no doubt that you will come out with useful directions and guidance to help us chart our future course on community-based health services.

Therefore, ladies and gentlemen, without any further delays, let me wish this consultation all success and I look forward to the report of the meeting.

Thank You
Traditionally, the WHO South-East Asia Regional Committee discusses a technical subject during its session every year. During this year’s session, the technical subject to be discussed next year is decided and is selected based on the importance of the subject to all Member States. Considering the successful achievements from community-based health services in the areas of communicable diseases, maternal, newborn, child, adolescent and reproductive health and also considering the challenges of prevention of noncommunicable diseases, “Strengthening Community-Based Health Services” was selected as the technical topic to be discussed at the Sixty-eighth Session of the Regional Committee to be held in Dili, Timor-Leste.

The Secretariat organized a technical discussion on this subject with country representatives and invited experts to discuss the topic and make recommendations. A meeting report of this discussion paved the way to develop the background paper required for the technical discussion at the Regional Committee. This background paper and recommendations were presented to the High-Level Preparatory Committee meeting and it was recommended that it be presented at the forthcoming Session of the Regional Committee.

Strengthening Community-based Health Care Services: Report of the Technical Consultation

WHO/SEARO, 15–16 June 2015