Upgradation of training of community-based health workers within the context of revitalization of PHC

Report of the Regional Meeting
Paro, Bhutan, 1-3 June 2010

World Health Organization
Regional Office for South-East Asia

SEA-HSD-337
Distribution: General

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Printed in India

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1. Introduction and background

Over three decades after the adoption of the Alma-Ata Declaration on Primary Health Care in 1978, although significant progress has been made much more remains to be done to achieve the goal of health for all.

The principles of primary health care—social equity, universal coverage, intersectoral coordination and people's participation—are still relevant in the prevailing epidemiological context—changing burden of disease, globalization, trade agreements, social determinants of health, and climate change.

The Regional Meeting on Revisiting Community-based Health Workers (CBHWs) and Community Health Volunteers (CHVs) held in Thailand in October 2007 recognized the importance of this category of health care providers in the delivery of primary care in the prevailing epidemiological context. It was recognized that strengthening CBHWs and CHVs formed the cornerstone of primary health care. The meeting concluded that there is a need for capacity building, research and linking of CBHWs and CHVs to the formal health system for better utilization. The meeting also recommended strengthening and supporting further development of public health workforce including CBHWs and CHVs at the grassroots level to tackle public health problems.

The Regional Conference on Revitalizing Primary Health Care held from 6-8 August 2008 in Jakarta, Indonesia, concluded that one of the crucial factors to revitalize primary health care was human resources, particularly at the community level and specifically recommended strengthening human resources and the service delivery system to support PHC, especially capacity building of CBHWs and CHVs, appropriate training of health workers consistent with the needs of PHC; review incentives for recruitment, deployment and retention of all health workers; improve the effectiveness of the referral system; and ensure availability of infrastructure and supplies.

In line with the above, Member States of WHO's South-East Asia Region have reaffirmed their commitment to revitalizing primary health care at various forums, in particular by adopting a resolution on Primary

Health Care at the sixty first session of the Regional Committee for South-East Asia held in New Delhi in 2008. Subsequently, this regional meeting on Upgradation of training of community-based health workers within the context of revitalization of PHC was held in Paro, Bhutan from 1-3 June 2010.

2. Inaugural session

Dr H S B Tennakoon, WHO Representative to Bhutan, while welcoming the participants, highlighted that Bhutan has a well established primary health care system but the biggest challenge is the rugged terrain compounded with scattered population. This regional meeting was not only timely but also in keeping with Bhutan's priority, i.e. capacity building of health workforce, particularly the community-based health workforce.

Dasho (Dr) Gado Tshering, Secretary (Health) read out the message from the Minister of Health, thanking WHO-SEARO and the WHO country office for the opportunity to host this very prestigious regional meeting. It was an opportune moment for Bhutan, as the Bachelor of Public Health (BPH) upgradation course (first batch) for senior public health workers had been recently launched with support from WHO-SEARO. Primary health care is the backbone of Bhutan's Health Care System and 60% of the health budget was allocated to PHC activities. The Royal Government of Bhutan attaches prime importance to the health care services and always allots 8-10% of the total Five Year Plan Budget. The Bhutanese people today enjoy totally free health care services at all levels including treatment outside the country, like in India or in Thailand those cases which can not be treated in the country. In spite of the scattered population difficult mountainous terrain and acute shortage of qualified and skilled manpower, Bhutan has achieved and sustained over 90% coverage of basic health services.

The inaugural address of Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia was read out by Dr Poonam Khetrapal Singh, WHO Deputy Regional Director, South-East Asia Region. The message highlighted the necessity of having a re-look at the health agenda in view of the rapid demographic, environmental, social, economic, political and epidemiological changes. In the context of epidemiological transition, wherein countries face the dual burden of communicable and

noncommunicable diseases, frequent occurrence of pandemics, ageing populations, lifestyle changes, rapid urbanization, high burden of injuries, effects of globalization, climate change and the economic crisis mandate a fresh examination of options that countries need to consider in their ongoing health development initiatives. Revitalization of primary health care with innovative action to address these issues is a vehicle through which health systems can be strengthened to meet the new and emerging health challenges in an equitable, efficient and effective manner.

Countries in the South-East Asia Region recognize the pivotal role that the community-based health workforce can play in realizing national and international health goals. Not only does this category of workers play a critical role in providing the continuum of health-care services but effective and imaginative utilization of their services provides an efficient mechanism for countries to accelerate efforts towards the realization of the Millennium Development Goals.

The message further highlighted that the resurgence of interest in primary health care provides a platform to revisit the agenda of community and population-based health services. The current situation needs attention to address the dual burden of communicable and noncommunicable diseases and the public health responses to current issues such as climate change and disaster preparedness. The emerging public health imperatives necessitate a relook at the capacity-building and service-related factors that impact the effectiveness of the existing community-based workforce. Upgraded training programmes for new entrants into this workforce are also needed.

The regional meeting on Upgradation of Training of Community-based Health Workers within the context of revitalization of primary health care will provide a platform to deliberate on several facets of upgradation of the community-based health workforce in South-East Asia with specific attention on upgrading training programmes. The Bachelor's Degree Programme in Public Health will provide a backdrop for the discussions. The rich experience and expertise that participants bring from Member States of the WHO South-East Asia Region will contribute to the deliberations and that the recommendations will help chart a roadmap to upgrade and professionalize the community health workforce in South-East Asia, the message concluded.

3. Objectives

General objective

To strengthen human resource at the community level for revitalizing primary health care.

Specific objectives

- To exchange countries' experiences on human resource development for revitalizing primary health care; and
- To demonstrate the competency-based public health curriculum of Bhutan to support revitalizing primary health care.

4. Technical session

4.1 Issues in revitalizing PHC in the South-East Asia Region

Dr Sudhansh Malhotra, Regional Adviser (Primary and Community Health), WHO-SEARO made a presentation on "Issues in revitalizing primary health care in SEA Region". He reminded the audience about the principles of PHC and drew a distinction between primary care and primary health care. He then highlighted the achievements in primary health care during the past three decades.

The following critical issues were presented on revitalization of primary health care:

Health in equities and barriers to access to health services:

Despite the significant contribution of PHC to the decline in communicable and vaccine preventable diseases, under-five malnutrition, and maternal, infant and child mortality rates, many countries are falling short of achieving the Millennium Development Goals. There are substantial inequities in health outcomes and accessibility to quality health care services within and between countries are substantial.

It was observed that many programmes were outstanding and delivered good results. However, a substantial number of programmes have paid overwhelming emphasis to addressing morbidity and mortality, but not enough attention has been devoted to those at risk who may develop certain diseases.

Most programmes focus on providing health care services by community-based health workers and volunteers to reduce existing morbidity and mortality. However, inter- sectoral collaboration remains a challenge. Few programmes have cooperated with other related sectors for socio-economic development.

The changing epidemiological profile

The overriding public health focus in the late 1970s and 1980s was on communicable disease and maternal and child health. Urbanization, industrialization, globalization and climate change have affected people's lifestyles that put them at risk of developing noncommunicable, chronic diseases such as coronary heart diseases, diabetes mellitus, hypertension and cancer. Faced with a dual burden of communicable and noncommunicable diseases, developing countries need to take a fresh look at options and approaches for managing the current burden of disease.

Increasing focus on specialized curative care and vertical programmes

Professional interests of medical practitioners combined with the profit motives of the health technology and pharmaceutical industry make health systems focus on specialized curative care rather than comprehensive care which is the original ideology of PHC. An increasing number of vertical programmes have emerged as "cost-effective" solutions to control specific diseases.

High out-of-pocket expenditure for health care – a significant contributor to impoverishment

With the commercialization of the health care services in the Region, it was highlighted that out-of-pocket (OOP) expenditure for health care in the Region has substantially increased. Data suggest that out-of-pocket

expenditure as a proportion of total expenditure on health was 65% in 2000 in Bangladesh, 82% in 2002 in India, 58% in 2001 in Indonesia, 75% in 1994-95 in Nepal, 50% in 1996-97 in Sri Lanka and 33% in 2000 in Thailand. Significant OOP expenditures on health are recognized as one of the most significant causes of indebtedness. The following five key elements for revitalizing PHC were explained:

- reducing exclusion and social disparities in health;
- organizing health services around people's needs and expectations;
- integrating health into all sectors;
- pursuing collaborative models of policy dialogue; and
- increasing stakeholder participation.

Practical steps for revitalizing PHC in the SEA Region include:

- Refocussing on communities by:
  - revisiting roles of CBHWs and CHVs;
  - community education and empowerment for self care;
  - health financing and social protection;
  - strengthen referral system.
- Addressing new challenges for primary health care through:
  - health or public policy and intersectoral collaboration;
  - focus on urban health; and
  - task shifting as a strategy for health equity and improving efficiency
- Planning for advancing primary health care by:
  - Health policy/plan review, and
  - Operational research.

4.2 Sharing of country-specific experiences

Village Midwife Programme in Indonesia

The presentation highlighted the significant increase in village midwives and village health posts since the introduction of the village midwife programme by the government. The presentation highlighted the following current problems:

- Discrepancy between province and district. With decentralization there is inadequate budget for the programme and unclear district policies.
- Politicizing health particularly by using it as a campaign issue in local and provincial elections.
- Gap between human resource production and requirement and problems in deployment and distribution.

The presentation also emphasized the need for strengthening the role of midwives in the following areas:

- Main activity – MCH and family planning
- Surveillance
- Community empowerment
- Health promotion
- Basic health services
- Capacity building in skill and management
- Supervision by health centre in facilitating village midwives
- Intersectoral collaboration at village level for community empowerment and allocation of adequate budget.

In order to overcome the current problems and to further strengthen the role of village midwives, the following strategies are being pursued:

- Health regulation to include midwives in every village and define status of midwives as civil servants or on contract;
- Policy should explicitly mention incentives and deployment of village midwives on priority in remote areas;

- Strengthening capacity of village midwives through continuing professional development;
- Ensuring adequate budgetary provision for village midwives by local governments under local health facilities, and
- Advocating the importance of the role of village midwives, particularly at the local, district and provincial levels.

Community midwives in Sri Lanka

The organizational structure of health services as presented, reflected the position at the provincial level and below and the position of the public health midwife (PHM) at the community level with a ratio of 1 PHM : 5000 population on average. Public health midwives in Sri Lanka are mainly responsible for the delivery of maternal, neonatal and child health care (MNCH), family planning, well-woman services, school health, mental health, elderly health including community-based rehabilitation, adolescent health, environmental sanitation (assisting public health inspectors) and maintaining and sending records on time. Therefore, PHMs are the cornerstone of the public health services in the country. A detailed job description including the supervisory system, pre-service and in-service training and career progression aspects were highlighted. Plans to revise, upgrade duties and functions to achieve health-related MDGs were presented as follows:

- MDG 1 – PHM to provide advice with regard to home gardening, and harmful effects of alcohol and tobacco use.
- MDG 4 – Several activities are carried out by PHM to reduce child mortality
- MDG 5 – Several activities are carried out by PHM to improve maternal health and reduce maternal mortality
- MDG 6 – PHM to contribute towards control of HIV/AIDS, TB, malaria, etc.
- MDG 7 – PHM to contribute towards preserving the environment.

Evolution of female community health volunteers (Nepal)

Because of the high maternal, infant and child mortality and low coverage of health services in the rural areas and more community problems associated with mothers and children, and also because of the involvement of male community workers had not been very helpful and recognizing the importance of women's participation in promoting the health status of the community, the female community health programme was launched in some districts in Nepal in 1988. This was started with one female community health volunteer (FCHV) per ward. The objectives of this programme were:

- To develop a self-help mechanism among rural women by providing basic knowledge on PHC with special focus on mothers and child health care;
- To enhance community involvement in PHC through mobilization of local women and resources, and
- To promote community participation for the best utilization of available maternal health, child health and family planning services.

This programme was expanded in a phased manner covering all 75 districts by 1995. At present, 48 549 FCHVs are functioning in the country. The 2006 NDHS survey found 90% and 84% coverage for vitamin A and de-worming respectively provided by FCHVs. They also play a major role in routine immunizations and polio campaigns. Currently, FCHVs are involved in implementation of health-related MDGs in Nepal. Nepal has very successfully implemented CB-IMCI through FCHVs. However, the programme is facing the following challenges:

- Deviation from volunteerism
- Full community ownership
- Sustainability of the programme
- Lack of proper incentives to sustain motivation
- Lack of training and inefficiency of media in updating the knowledge of FCHVs.

Primary health care in DPR Korea

The presentation highlighted the global challenges in primary health care, followed by the development of primary health in DPR Korea which has taken place in four stages beginning from 1945. How the free medical care system in the country is sustained was also explained. In the section Doctor system followed in DPR Korea, doctors are responsible for health care, prevention and medical services for the population in a section under their charge. Under the household doctor system, implemented since 1988, a household doctor is responsible for universal and comprehensive health care of a household.

Capacity strengthening of PHC health workers in the country is implemented through:

- Inclusion of public health in medical university curriculum
- Regular reorientation / in-service training for health workers
- Introduction of newly developed training material for in-service training of household doctors
- Development of references for household doctors
- Training of health volunteers
- Increasing number of health workers
- Preventing flow of health workers to city/ urban areas.

The following experiences in strengthening PHC were shared:

- PHC is the right approach to implement the health for all strategy.
- Only with strong national policy and powerful support of the government and community can PHC be successfully developed.
- PHC development can be ensured when recruitment and training of health workers is well organized and their technical and practical capacities improved.

4.3 Review of regional situation on CBHWs for the revitalization of primary health care

Dr Muzaherul Huq, Regional Adviser (HRH) and Fellowships Officer, WHO-SEARO, highlighted the variation in PHC policies, the PHC delivery system, training approach and management in SEAR countries, and the overall shortage of workforce. Uneven distribution, inadequate competency and improper HR management were cited as the major challenges. To overcome these challenges, he proposed three strategic pillars, i.e., (i) renewing political commitment and recognizing the importance of CBHWs and CHVs; (ii) strengthening the CBHWs and CHVs, and (iii) ensuring a supportive environment for their effective functioning. He further proposed the following strategic actions for community-based health workforce to revitalize PHC:

- Identifying needs for community-based health actions
- Mapping out community-based health workforce and revisiting its roles
- Revising policies towards community-based health workforce, and
- Reviewing curriculum for education and training.

A way forward was proposed with the following immediate steps:

(1) Mapping existing community-based health workforce

(2) Reviewing and updating its roles and responsibilities

(3) Revisiting, reviewing and updating the education and training programmes.

Further steps need to be taken for:

- Strengthening professional and regulatory bodies
- Establishing an accreditation mechanism
- Establishing a system of continuing education with continuous professional development programme, and
- Encouraging and supporting research.

4.4 Presentation on Bachelors in Public Health (BPH) programme

The presentation on the Bachelor in Public Health (BPH) programme by Dr Chencho Dorji, Director, Royal Institute of Health Sciences (RIHS), Thimphu, Bhutan, started with a brief background on the history of the Institute, highlighting the training programmes of the Institute and Bhutan's health care system. The upgradation of the BPH programme for health assistants was initiated to improve the quality of health care services; to ensure equitable, efficient and effective management of the health system; facilitating capacity building of community-based health workers towards revitalization of primary health care, and to provide an opportunity to the CBHWs to become professional health workers.

It is a modular two-year programme offered in four semesters. The intake capacity for the programme is 25 students per batch and the selection is on merit. The lectures constitute 30% of the programme, and 40% is lab/practicum. 50% of the programme is self-study, and problem-based learning. Assessment comprises 50% formative and 50% submitive. After successful completion of the course, graduates are expected to take a leadership role in health to:

- Empower people to take care of their own health
- Communicate effectively with clients and stakeholders
- Manage information and its use in evidence-based decision making
- Plan, implement and evaluate public health programmes
- Build partnerships and collaboration with relevant agencies
- Promote health and prevent diseases, injuries and disabilities
- Think systematically and critically in their everyday duties.

5. Field visit

The participants were divided into three groups with resource persons. Each group was also given the following specific objectives:

Group 1: To visit RIHS to observe the system adopted by RGOB of CBHWs and also how competency-based issues are addressed in the curriculum.

Group 2: To visit Institute of Traditional Medicines (ITMS) to observe how the traditional medicine system is being incorporated to provide health care in the country and also to see how traditional medicines are manufactured.

Group 3: To visit Dawakha Basic Health Unit to observe the kind of places the community health workers are being posted to in order to provide PHC services to the rural community in Bhutan.

Observations on field visit

Group I observed that the infrastructure, faculty and logistics at RIHS were generally of acceptable level. The strength of the Institute is: (i) high standard curriculum meeting University's requirement, (ii) schedule was good, (iii) faculty exposed to training technology (iv) students selection system in place (v) campus + hospital + health services well integrated and complementing each other, and (vi) the degree is awarded by the Royal Bhutan University (RBU). However, the challenges were: (i) to make the course more relevant to the needs of the country, (ii) need for more qualified national faculty in place, (iii) accommodation for students and faculty in the campus, (iv) IT skills for students, (v) training to be more field-oriented, and (vi) more appropriate student assessment method to be adopted.

Group 2 observed the indigenous medical system in Bhutan at ITMS, Thimphu:

Observations:

- Three components: service, training and drug manufacturing of indigenous medicines.
- Indigenous medical system is an accepted and approved system of health care in Bhutan
- Amalgamated with the health care system

- Indigenous medical facilities in the country: NITM (National Institute of Traditional Medicine) - 1; TM units in districts - 39; BHU level monthly visit by sMenpas
- NITM started producing sMenpa from 1971 onwards:
- Drungsto since 1978
  - Currently there are 47 Drungsto, 63 sMenpa, 12 Pharmacy Assistants, and 11 research assistants in the country
  - NITM is a federated college of Royal University of Bhutan.

Pharmaceutical and Research Unit:

- 20.51 tons of raw material used annually; 85% available in Bhutan, 15% is imported
- Good manufacturing practice in place
- 265 types of raw material are used to produce 108 compounds out of which 98 products constitute essential list of TM

Challenges:

- conservation and production of herbs
- promoting evidence-based research: preclinical and clinical trial on drugs and diagnosis based on pulse reading and urine examination
- Financial/resource constraints

Recommendations:

- to promote conservation and production of herbal plants
- to scientifically validate the efficacy and safety of traditional medicines (TM)
  - through preclinical and clinical research on drugs
  - clinical research based on pulse reading and urine examination

- WHO to continue support for further promotion of the TM system

Group 3 observed PHC services provided at the Basic Health Unit (BHU), Dawakha, Paro district:

Observations:

- Preventive, promotive and curative services provided by Health Assistants, Auxillary Nurse Midwife and Basic Health Worker.
- Facility Based Services
  - Minor illnesses
  - Immunization
  - Antenatal Care
  - Delivery
  - Health promotion
- Outreach clinics and home visit
- Referral services
- NCD project
- Adequate infrastructure as per function:
  - OPD
  - Lab
  - Day care facility
  - Labour room
  - Immunization clinic with adequate cold-chain facilities
- Good record keeping
- Adequate display of IEC materials
- Essential drugs as per approved list available
- Free services
- Cleanliness level good
- Staff motivated and skilled in their job responsibilities

Group 3 recommendations:

- Identify reasons for underutilization and by-passing of BHU for increasing utilization.

6. Panel discussions

The panel discussions were moderated by Dr Abraham Joseph and the panel members were: Dr L M Nath (Service delivery package at primary health centre), Dr K C S Dalpatadu (Education and training of health workforce at primary health centre), Dr Thin Maung Chit (Continuing professional education for health workforce at primary health centre – opportunities and challenges), and Prof Oranut Pacheun (Management of community-based health workers).

6.1 Service delivery package at Primary Health Centre

The essential elements of primary health care were defined as universal coverage, people-centred care, inclusive leadership and health in all policies. PHC has to serve three masters – politicians, Ministry of Health authorities, and the general public. The importance of social determinants of health and noncommunicable diseases were emphasized in the context of PHC. The minimum essential package for PHC was defined as follows:

- Medical care in illness and injury
- Maternity care, antenatal and post-natal care
- Health care, both preventive and promotive
- Community participation for health
- Training, supervision of para-medical staff and community health volunteers
- MIS and registration of major illnesses, births and deaths.

6.2 Education and training of health workforce at primary health care level

It was highlighted that the over-arching PHC workforce goal is:

> "The right ***people*** at the right ***places*** and ***time*** with the right ***competencies*** and with the right ***resources*** and ***support".***

The following challenges and strategies for education and training of health workforce at PHC level were presented:

- Preparing the work force
- Planning
- Education
- Recruitment

It was emphasized that information needed for planning and education, particularly data on existing educational institutes and its curricula, capacity intake of trainees and output, competencies of staff and quality of training were crucial for developing a need-based PHC workforce for the country.

The following strategies were suggested for overcoming the current challenges in PHC workforce, education and training:

(1) ***Reduce attrition*** among students and teachers, and improve accessibility;

(2) ***Integrate*** pre-service and in-service education and training (links with services);

(3) Develop ***common educational platforms*** for different types of health workers (e.g. team based);

(4) ***Move learning to the community***, using modular education and action learning;

(5) Increase use of ***information and communication technologies***, and

(6) Improve education through ***quality assurance*** programmes.

6.3 Continuing professional education (CPE) for health workforce at primary health centre – opportunities and challenges

The aim of CPE was presented as "Continuing Professional Education for health workforce at Primary Health Care level includes all activities that PHC providers undertake formally and informally in order to maintain, update, develop and enhance their knowledge, skills and attitudes in response to the needs of their community" as a result of which PHC providers ensure that they maintain and develop the competencies necessary to meet the needs of society. Various learning methods, planning and documentation for CPE activities were highlighted, including education contents and resources, evaluation of methods and competencies. Current challenges faced in CPE are as follows:

- Ensuring adequate budget and resource allocation as an integral part of the existing medical and health care practices;
- Commitment by the government on emphasizing the perceived needs of PHC providers in the planning and documentation;
- Regular feedback mechanism like formative learning for relevance and quality of CPE and
- Promoting routine recognition and reorientation for PHC providers.

CPE should take advantage of the following opportunities:

- Existing established health care delivery system and professional associations;
- Increasing support and interest from UN and international non-governmental organizations (INGO);
- Better networking among relevant stakeholders within and outside the country; and
- Use of available information technology

6.4 Management of community-based health workers

To begin with, one should know the definition of community-based health workers (CBHWs), their roles and responsibilities and the competencies and skills required. Sample competency and the "iceberg" model of competency were highlighted. In order to manage CBHWs effectively and efficiently, the following issues need to be considered:

- Mechanism to protect their rights (professional body)
- Promotion/career ladders
- Participation and support from civil society, local administrative organizations
- Revise/define proper tasks
- Strengthen managerial competency
- Other motivation/incentives

In addition to the above, the following support system needs to be in place for effective and efficient management of CBHWs:

- health information system
- Real-time consultation
- Referral system
- Emergency medical service
- Drug and medical equipments
- Participation and support from local administrative organizations, civil society

A case study of a recent initiative of a sub-district health promoting hospital in Thailand was also highlighted.

7. Group discussions

The presentation of Group 1 on "Education and training and continuing professional education" highlighted that countries should:

- Take stock of their CBHWF-a database
- Map training institutes and regulatory bodies
- Map training programmes
- Ensure that training is knowledge based/competency based, relevancy, appropriateness, user friendly
- Assessment of trainers- competencies, numbers level
- Standards-existing, develop, adherence
- Strengthening of regulatory bodies or support formation of new ones

Continued Professional Development:

- Should be for all CBHW
- Opportunities be available
- Institutionalized
- Need based, practice/skills oriented
- Involve both institutional and field based faculty/supervisors
- Incentives-credit system, increments, promotion, career advancement

The presentation of Group 2 on "Health Service Delivery at PHC" included:

- Task-based /outcome training
- Full team supervisory meeting with the DHO (monthly?, quarterly?)
- Develop a clear roles and areas of performance descriptions of the levels of health facilities in general , individual performances expectation

Supplies and logistic information

- A well defined standard guidelines for logistics and supplies as per the disease pattern and need

- Supplies should include relevant IEC materials
- Good system of refill and redistribute system at the PHC facilities
- A good buffer stocking system
- Training of the stock managers and use
- Computer based drug, supply, personnel information .

Monitoring of QI

- The CBHW (entire team) should have an agreed set of performance indicators for different levels. The targets must be set for all levels of care
- Regular audit and supportive supervision of the performance targets by time cycle
- Build the accountability system

Problems faced in referral system

- A good referral guidelines from the community –Health facility-higher up
- Training of the CHVs
- Recognition of the referred cases (Develop a proper gate keeping system policies)
- The household level delays- how to improve health seeking behaviors(local healers, household decisions)

The presentation of Group 3 on "Community-based Health Workforce Management" included:

Issues in Management of CBHWF:

- Availability and effectiveness of National Health Workforce Policy and Planning
- High number of vacant positions
  - Reasons and remedies

- High turnover of workforce at community level
  - Reasons and remedies

National Health Workforce Policy and Planning

- Need high level of Political Commitment
- Develop need based norms based on :
  - Population
  - Geographic terrain
  - Population Density
  - Hard to reach, conflict areas and marginalized groups
- Define role of CBHWs based on evidence based health needs
- Criteria for selection according to local conditions and needs for all levels of CBHWs should be locally recruited with community involvement
- Institutionalize pre-service and in-service training and make them need based
- Define service conditions and carrier progression
- In-built incentives for working in rural and difficult areas
- Periodic review of Policy to meet emerging needs

High number of vacant positions and High Turnover

- Give preference to local persons during recruitment.
- Adopt realistic and appropriate recruitment criteria.
- Wherever necessary decentralize recruitment to local governments.
- Incentives – financial (direct and indirect e.g. housing loans micro credits) and non-financial such as rapid promotions, in-service training, children's education, housing for working in difficult areas.
- Provision for spouses to be placed in same location.
- For CHV's build mechanisms for social recognition.

- Special health benefits (up to tertiary level) for CBHWs and CHVs.
- The community, local authorities and formal and informal leaders should be involved in implementing action for retaining staff in rural and difficult areas.

8. Conclusion and recommendations

Conclusions

Primary health care (PHC) is a multidisciplinary, comprehensive approach that encompasses health promotion, disease prevention, treatment and rehabilitation and addresses the social, cultural, economic, and environmental factors that cause ill health as well as those that sustain and maintain health. Countries in the South-East Asia Region have adopted PHC as an integral foundation on which their health systems have been built. Member States have developed different models of PHC taking into account their national contexts. PHC has contributed significantly to the decline of communicable diseases as well as maternal and child mortality in the Region. These gains have been made by the involvement of community-based health workers and volunteers.

The principles and approaches of PHC, as enunciated in the Alma Ata Declaration, are still relevant, however, in the changed social, economic, demographic and epidemiologic context, PHC needs to be re-vitalized for achieving universal coverage to reduce inequities between and within Member States. The capacity of the community-based health workforce, which has been functioning as a corner-stone of PHC in the Region, needs to be upgraded to address the emerging challenges of urbanization, climate change, public health emergencies, and the increasing burden of noncommunicable diseases.

The community-based health workforce (CBHWF) comprise of both non-professional community health volunteers (CHVs) and professional community health workers (CHWs). The South-East Asia Region lacks specific strategies for standardizing the functions/tasks, training, registration, recruitment, retention, continuing education, and career advancement of CBHWF. The Bachelor of Public Health (BPH) programme designed by the Royal Institute of Health Sciences, Bhutan for upgradation of the knowledge and skills of CBHWF has the potential of strengthening the revitalization of PHC in the Region. The unique feature: giving an

opportunity of CBHWF to join a formal education course that will improve their career path but also should improve productivity.

Recommendations

For Member States

(1) Review national health policies and plans to identify the roles and responsibilities of CBHWF for revitalization of PHC.

(2) In the changed socio-economic, demographic and epidemiologic context, assess community health needs/actions and identify actions/tasks that CBHWF can undertake in the community.

(3) Design competency-based courses/training programmes for CBHWF to upgrade their knowledge and skills in relation to the key elements of PHC revitalization.

(4) Develop an adequate system including an accreditation mechanism for training and continuing education of CBHWF and appropriate recognition.

(5) Develop strategies for the recruitment, retention, continuing education and career advancement of CBHWF.

(6) Encourage ownership and partnership of communities and other stakeholders in formulating policies and plans for CBHWF development.

(7) Encourage voluntary contributions and partnership with community-based organizations and mobilize resources for sustaining the community-based services provided by the CBHWF.

(8) Set up systems for periodic assessment of the performance of CBHWF and create a mechanism for linking financial and non-financial incentives with performance.

(9) Ensure adequate administrative and regulatory safeguards for efficient functioning of CBHWF.

(10) Create career progression pathways for CBHWF through upgradation of their knowledge and skills through certified diploma/degree courses such as Bachelor of Public Health.

(11) Maintain a data base concerning population, CBHWF.

(12) Map out the CBHWF and training institutes and programme in the country.

For WHO

(1) Support the Member States in terms of technical resources for upgradation of training of CBHWF.

(2) Support and facilitate collaboration between Member States and beyond, to enhance knowledge, skills and competencies of CBHWs by sharing good practices, guidelines, etc.

(3) Set up a mechanism for involvement of public health institutions/professionals from Member States for the development of standards and accreditation of courses/training programmes for upgradation of training of CBHWF.

(4) Support incorporation of IT facilities for provision of better quality PHC services including training at the community level.

For Member States and WHO

(1) To carry out operation research on health workers and educational needs for revitalization of primary health care.

9. Closing session

Dr Poonam Khetrapal Singh, Deputy Regional Director, WHO-SEARO thanked the Royal Government of Bhutan, and in particular the Ministry of Health for hosting the regional meeting. She also thanked all the participants for their active participation and producing very practical and useful recommendations which will be followed up by the concerned technical units in WHO-SEARO.

The meeting was formally closed by the Chairperson, Dasho (Dr) Gado Tshering.

Annex 1

List of participants

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Annex 2

Provisional agenda

(1) Inaugural Session.

(2) Review of the regional situation on Revitalization of Primary Health Care.

(3) Sharing of country-specific experiences:

  (a) Village Midwife Programme in Indonesia.

  (b) Community Midwife in Sri Lanka.

  (c) Medical Assistant Training in Bangladesh

  (d) Task Shifting by Nick Simmons Institute, Nepal.

(4) Review of regional situation on community-based health workers for revitalization of primary health care

(5) Presentation on Bhutan BPH Programme.

(6) Field Visit

(7) Panel discussions by health sector development partners

(8) Group discussions

(9) Group presentations

(10) Conclusions and recommendations.

(11) Closing Session

Annex 3

Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region

Distinguished participants, ladies and gentlemen,

I have the honour to present greetings from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, to the distinguished participants of the *Regional Meeting on Upgradation of Training of Community-based Health Workers within the Context of Revitalization of Primary Health Care*. I warmly welcome you all and thank you for sparing your valuable time to participate in this important event. As the Regional Director is unable to be present here today, I have the privilege of reading out his message.

Over the past few decades the world and countries in the South-East Asia Region have witnessed rapid demographic, environmental, social, economic, political and epidemiological change. This transition necessitates a relook at the health agenda to customize our responses to the current health development needs. There is widespread consensus that the overarching principles of primary health care: social equity, universal coverage, intersectoral coordination and people's participation remain valid and that health systems strengthening should be based on PHC values, principles, and approaches.

Epidemiological transition, wherein countries now face the dual burden of communicable and noncommunicable diseases, frequent occurrence of pandemics, ageing populations, lifestyle changes, rapid urbanization, high burden of injuries, effects of globalization, climate change and the economic crisis mandate a fresh examination of options that countries need to consider in their ongoing health development initiatives. Revitalization of primary health care with innovative action to address these issues is a vehicle through which health systems can be strengthened to meet the new and emerging health challenges in an equitable, efficient and effective manner.

Member States of the South-East Asia Region have reaffirmed their commitment to revitalizing primary health care in various forums. Notable among these is the adoption of a resolution on primary health care in 2008 by the WHO

Regional Committee for South-East Asia that enjoins Member States and WHO to continue to work towards strengthening primary health care in the Region. Other seminal events including the Regional Conference on Revitalizing Primary Health Care held in Indonesia in August 2008, and the earlier Regional Meeting on Revisiting Community-based Health Workers and Community Health Volunteers held in Thailand in October 2007, recognized the importance of these categories of health-care providers in the delivery of primary care in the prevailing epidemiological context. It was recognized that strengthening community-based health workers and community health volunteers form the cornerstone of revitalizing primary health care.

Countries in the South-East Asia Region recognize the pivotal role that the community-based health workforce can play in realizing national and international health goals. Not only does this category of workers play a critical role in providing the continuum of health-care services but effective and imaginative utilization of their services provides an efficient mechanism for countries to accelerate efforts towards the realization of the Millennium Development Goals.

The resurgence of interest in primary health care provides a platform to revisit the agenda of community and population-based health services. The current situation needs attention to address the dual burden of communicable and noncommunicable diseases and the public health responses to current issues such as climate change and disaster preparedness. The emerging public health imperatives necessitate a relook at the capacity-building and service-related factors that impact the effectiveness of the existing community-based workforce. Upgraded training programmes for new entrants into this workforce are also a need of the hour.

Like several other countries of the Region, Bhutan has been successful in the development of a community-based health workforce. Large numbers of health assistants, auxiliary nurse midwives and basic health workers have greatly contributed to the successful development and implementation of community-based services in the country. They have contributed significantly to the visible improvements in the health status of the Bhutanese people. Currently, about 90% of the population is covered by primary health care services. This has led to a significant increase in life expectancy from 47.5 years in 1984 to 66.1 years in 2005. Infant mortality decreased from 70.7 per 1000 live births in 1994 to 40 in 2005. Maternal mortality declined from 380 per 100 000 live births in 1994 to 225 in 2000.

As in several other countries, till very recently, the avenues of career advancement for community-based health workers in Bhutan were rather limited. In this regard, the Royal Government of Bhutan took an important step in April 2010 to launch the Bachelor's Degree Programme in Public Health. This course will be offered to the community-based health workers. The Royal Government of Bhutan deserves all congratulations for this very important milestone in the history of health development in the country. Improving the education of the community-based workforce in Bhutan is a very welcome step towards professionalizing it. It will not only provide better career avenues to the workers but also improve skills and competencies and would contribute immensely to further improve the health status of the people of Bhutan.

The Regional Meeting on Upgradation of Training of Community-based Health Workers within the Context of Revitalization of Primary Health Care will provide a platform to deliberate on several facets of upgradation of the community-based health workforce in South-East Asia with specific attention on upgrading training programmes. The Bachelor's Degree Programme in Public Health will provide a backdrop for the discussions. The rich experience and expertise that participants bring from Member States of the WHO South-East Asia Region, will contribute to the deliberations and the recommendations will help chart a roadmap to upgrade and professionalize the community health workforce in South-East Asia.

On my behalf, I take this opportunity to thank the Royal Government of Bhutan for their hospitality and the excellent arrangements made for the meeting. I extend my best wishes to the participants on behalf of the Regional Director and on my personal behalf for successful deliberations and a satisfying outcome of the meeting.

Countries in the WHO South East Asia region have reaffirmed their commitment to revitalizing Primary Health Care in several forums in the recent past. Community based health workers (CBHWs) are the backbone of primary health care services in most countries in the South East Asia region. Given the imperatives due to the changing epidemiological and demographic scenario the training of CBHWs needs to be upgraded. Further, there is an urgent need to upgrade the professional avenues for this category of the workforce. WHO/SEARO has supported the development of the Bachelor in Public Health programme for upgrading the professional skills of the community based workers in the country. The Regional Meeting was organized to discuss this and other experiences in upgradtaion programmes for CBHWs. This report is an account of the experiences shared in the meeting and includes recommendations for member-states and WHO/SEARO for upgrading the training programmes for CBHWs.

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SEA-HSD-337