



What Works for Children in South Asia **COMMUNITY HEALTH WORKERS**

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COMMUNITY HEALTH WORKERS

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Introduction

In recent years, many countries have expanded their health systems by training community health workers (CHWs) on a large scale. These CHWs are either paid or voluntary workers. They are part of government or national programs, and differ from CHWs trained in small-scale, often non-government projects influenced by charismatic leaders and funded externally. The success of small, well-managed projects is evident in the literature and there is ample evidence that CHWs in small-scale well-managed projects can be effective.

However, it is much less clear about the large-scale national CHW programs being effective and making a difference in peoples' lives. Voices have been raised questioning, among other things, meeting people's needs, the quality of their work, the amount of work they do, attrition rates, the precedence curative or facility work takes over preventive or community work etc. (Gilson et al 1989).

What is the evidence of CHWs in South Asia? There is no documentation yet at the regional level on this specific matter. In this backdrop, the paper looks at national, large-scale programs in five countries of South Asia (namely Bangladesh, Bhutan, India, Nepal and Sri Lanka) and reviews the existing policies, practices and lessons learned within the overall context of primary health care in these countries, hoping that it will help the community health practitioners, program managers or policy makers of the countries in the South Asia region to adapt, replicate and/or scale up the best evidences and learn from the mistakes.

In summary, the main objective of this paper is to reexamine the implementation of national CHW programs and document the evidence based-knowledge or best practices in South Asia.

The paper is primarily based on the internet search and a review of published and unpublished literature on CHW national programs in South Asia.

Community Health Workers: Who are they?

Since the role of the community health worker was re-emphasized during the Alma Ata conference in 1978, there have been several variations and definitions of this term. Globally, they are called by a variety of names including Health Auxiliaries, Barefoot Doctors, Health Agents, Health Promoters, Family Welfare Educators, Health Volunteers, Village Health Workers, Community Health Aides, Community Health Volunteers and Community Health Workers. With the varying demands and differing levels of health within countries, regions, districts, and villages, each community has its own version of the community health worker.

According to WHO, "CHWs are men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations" (WHO 1990).

Witmer et al (1995) define community health workers as community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care. By identifying community problems, developing innovative solutions, and translating them into practice, community health workers can respond creatively to local needs.

Walt (1989) provides the following definition of CHWs:

...generally local inhabitants given a limited amount of training to provide specific basic health and nutrition services to the mothers of their surrounding communities. They are expected to remain in their home village or neighborhood and usually only work part-time as health workers. They may be volunteers or receive a salary. They are generally not, however, civil servants or professional employees of Ministry of Health.

In addition to the various definitions that are applied to the CHW, there are also many different titles that are used. Table 1 is a list of alternative titles used for Community Health Workers in South Asia. In this report, the term CHW will be used for all kinds of these titles, with the local titles referring specific examples, where necessary.

Table 1: Alternative Titles for Community Health Workers	
Shasthyo Sebikas	Bangladesh (BRAC)
Village Health Worker	Bhutan
Village Health Guide	India
Female Community Health Volunteer	Nepal
Community Health Worker	Sri Lanka

Country Experiences

A review of the published literature on CHW reveals that there is a large body of papers and reports describing many small-scale locally initiated projects by NGOs, specifically designed field experiments and official pilot projects. In these reports one can find many variations on CHW selection, training, incentives, management etc. In contrast, there are very few papers and reports available documenting large-scale national programs. While scientific studies of impact are rarer, there are evidences that suggest dramatic improvements can be achieved with well-designed and run community-based health volunteer programs. This paper is mainly based on review of such large-scale national programs in five countries of South Asia, namely, Bangladesh, Bhutan, India, Nepal and Sri Lanka.

Bangladesh

In Bangladesh, the government has provided a few essential services and encouraged NGOs to work with communities through a large array of approaches to provide responsive health and development initiatives. Hence, there is not one standard model of community health program forced by government but rather a proliferation of efforts by nongovernmental organizations, most with a firm base in the community (Wyon et al 2002). The experiences of NGOs range from national house to house education efforts by BRAC, one of the largest national nongovernmental organizations in Bangladesh, with their unsalaried community health workers (called *Shastho Shebikas*), teaching every woman how to prepare oral rehydration solution to treat diarrhea to the efforts of World Vision/Bangladesh with community partners; experience of the Local Initiatives Program and the *Jiggasha* approach with community collaborators or, ICDDR/B to empower the communities to take full control of their health with the help of community health workers (Wyon et al 2002; Perry1999)

The BRAC health program addresses the health and nutritional status of women and children in Bangladesh and covers 35 million people with approximately 25,140 *Shastho Shebikas* (SSs). The concept of SS was first introduced in 1977 through a small-scale integrated health

development program in five sub-districts. Subsequently the approach was found to be successful and expanded into another 21 sub-districts in 1992 and then to 330 sub-districts by 1999 (Hossain1999).

As the BRAC experience with SS at national scale provides compelling evidence that local-level community health workers can effectively provide health services to the entire local population, this paper primarily highlights on BRAC's experiences with the SS.

Selection of Shastho Shebikas

The SSs are members of the BRAC village organizations, that consist of women from the poorest communities and which are aimed at improving their socio-economic conditions. In the beginning of the program, five women form a group and about ten such groups constitute a village organization in each community. These village organization members suggest names of prospective SS during the village organization meetings. Based on these recommendations, the final selection of SS is done at BRAC's regional office.

Selection of SS is based on the following criterion: female, socially acceptable, age 25 to 35 years, married, youngest child's age above five years, eager to do work, preferably educated, not living near a local health care facility or big bazaar. They are not paid a salary but they retain a small profit from the sale of drugs prescribed for common illnesses (Khan et al 1998, Hossain1999).

Role of Shastho Shebikas

The breadth of the health activities of SS in community based health care is quite extensive, especially considering that SS are illiterate (or, at best semi-literate) and unsalaried (Perry1999). The SSs give health education, motivation, and mobilization regarding the five components of Essential Health Care program which consists of water and sanitation, immunization, health and nutrition education, family planning and basic curative services. Each SS facilitates 150-300 households for their health care needs and also to link them up with BRAC's multi-dimensional development interventions (Hossain1999). They sell medicine, contraceptives, sanitary latrines, tube-wells, and vegetable seeds. They

diagnose, treat, and provide health education on diarrhea, dysentery, fever, common cold, anemia, worm infection, gastric ulcer, allergic reaction, scabies, and ringworm infection.

The SSs go on follow-up visits in the afternoons and encourage pregnant women to utilize government facilities. Furthermore, the SSs are involved in attending their daily household chores, village organizations related income-generating activities, establishing liaison with government health workers, and preparing and submitting monthly progress reports. Total monthly working days for each SS are 15 (Khan et al 1998).

Training

The SSs are given foundation or basic training on essential health care, which lasts for 21 days, at 4 days per week at the regional office. Then refresher training is given for one day every month for two years (BRAC website, Khan et al 1998).

Incentives/motivation

According to Khan et al (1998), there are various motivational factors for becoming a SS e.g. to do some work for children, to earn a profitable income, to have access to medicine, to make people aware about contraception and immunization, to learn about health and hygiene of her own children and neighbors. Additionally, the SSs think that if she or anyone in the village became ill there would be an advantage in knowing all this health information and to earn name and fame if she gave treatments for such illnesses.

For making the SS economically self-dependent, BRAC supplied credit to the SS so that they could undertake small income-generating activities such as poultry raising (Lovell et al 1993).

Monitoring/follow up

BRAC's program organizers (POs) provide supportive supervision and technical advice to SSs. Each PO supervises 25-30 SSs and visits each SS two to three times per month. The PO also visits 25% households served by SS as part of routine monitoring (Hossain 1999).

Replication/Scaling up

Lovell et al (1993) note that BRAC has been able to scale-up its health programs (e.g. nation-wide, single purpose oral rehydration teaching program reaching 13 million households, Child Survival Program assisting government in immunization covering a third of a the country) through replication of best practices. After the development stage at one place (i.e. at Sulla), where the idea was tested, changed, retested and tried again, it was replicated later in many other areas. A strong monitoring and evaluation program made it possible to identify weaknesses that could be corrected before scaling up to the next level.

Analysis of BRAC's experience suggests that several factors are essential for successful scaling-up. Primarily, they are related to qualified, experienced and dedicated human resources to support the program; effective management systems (including monitoring and evaluation systems) and capabilities in the organization; learning environment (generating ideas from interaction with the field and encouraging learning in and between all levels of the organization) and adequate financial support.

Sustainability

Khan et al (1998) reported that the drop out rate for SS ranged from 31 percent to 44 percent. Some dropped out after only a few months and there were others who did so after a few years of service. There were multiple reasons for discontinuing the work: lack of time due to more time spent looking after little children and doing household chores, not much profit earned from selling medicine, more profit earned from other activities, too much effort spent for too little profit, could not find enough customers to sell medicine to, target set by office too high to be achieved, unwillingness to do this work without a salary, people buying medicine on credit purchase basis, people reluctant to buy medicine because of their perception that BRAC got the medicine free, availability of cheaper medicine at the local bazaar, preference for buying medicine from local shops, family members disliked the work, socially unacceptable for a woman to do this work etc.

BRAC has learned that progress cannot be made on health issues without the full involvement and leadership of women. It has also proved that, once empowered, the poorest illiterate women can become leaders

in health improvements. By developing strong, better educated and empowered village groups, capable of utilizing and making demands on government health services, a higher quality of preventive health measures will be practiced in the community (Lovell et al, 1993)

Constraints/Challenges

The major challenge is that could the BRAC model be adopted by the government at national level. As successful implementation of the voluntary program needs intensive monitoring and supervision, would it be easy for the government to institutionalize an intensive monitoring system similar to that of BRAC and to integrate volunteering into the formal health program (Hadi 2003).

A Case Study: Reasons of CHW Dropout

Khaleda was a 25-year-old married woman with one living child, and a family of three. She had studied up to Class 5 in a government school. She had been a Village Organization (VO) member for eight years. Her main income source was from VO-related activities. Her current credit status amounted to \$70. She invested this loan in a fishery project for which she had received a one-day training. She worked as an SS for two-and-a half years. She received a 16-day training on SS work, which had included the identification of sign/symptoms and treatment of certain illnesses. She became an SS to help the poor of the country. She had also thought that she would earn big profits from this work, because BRAC Program Assistant had said so. She quit the SS work because she earned little profit after walking around all day leaving her household chores unattended. After walking so much, a profit of \$0.02 from selling a specific medicine, saying BRAC medicine was not good or it was more expensive or BRAC got the medicine free so why should they pay for it. Khaleda opined that this type of work could not be done without a salary. Moreover, her husband used to get angry because she went off and locked the door and he would come home from work and not be able to get inside. Thus he asked her to stop working.

Source: Khan et al (1998). Training and retaining Shasthyo Shebika: Reasons for turnover of community health workers in Bangladesh

Bhutan

Royal Government of Bhutan, Ministry of Health initiated the Village Health Worker (VHW) program in 1979 with the training of first batch of volunteers at Thimpu. The basic philosophy of VHW program in Bhutan was to establish a link between the community and the health services. The concept of Primary Health Care (PHC) is disseminated to the community through this group of volunteers, including improvement of basic hygiene and sanitation, prevention of vaccine preventable diseases and other preventive and promotive aspects of health. (Government of Bhutan, MOHE; Namgyal 1994)

The VHW program has two main objectives (Government of Bhutan, MOHE):

- to increase people's access to health care services thus, enhancing the health coverage in the country and
- to improve health and hygiene practices of the people in the communities through dissemination of health information and provision of simple treatment and first aid.

Selection of VHWs

The communities select the VHW following a set of criteria which are as follows (Government of Bhutan, MOHE):

A VHW must be:

- confident, trusted and popular in the community,
- living permanently in the community and not frequently absent,
- a good example in terms of personal hygiene, health care and community participation,
- healthy and physically able to fulfill the role of VHW,
- sufficiently confident to attend the training
- willing to be a VHW for at least one year

While selecting, priority should be given to the villages which are more than one hour walking distance from the nearest health centre. One VHW covers more than one village if the villages are small and close by (approximately 20-30 households).

Role of VHWs

The VHWs are not an integral extension of the national health system, but a complimentary force to support the activities of the health system for the enhancement of health of the people. The role of a VHW is to spend a fraction of his time carrying out health related activities in his own community. It is not envisaged that a single VHW cover a large population, nor is the VHW expected to spend all his time for this; he is only a part time volunteer

The VHWs are supposed to be primarily the link between the community and the health system. They are expected to be able to provide health education towards better health care, including family planning, provide simple first aid treatment for emergencies and minor illnesses, notification of the outbreak of any epidemics in the community, recognizing danger signs and symptoms of serious and chronic patients, playing an important role in out-reach clinics and expanded program of immunization and referral to the nearest health centre. They are also expected to participate in any development activities in the community, for example electricity and water programs (Government of Bhutan, MOHE; Danida 2001)

Training

Although the Village Health Worker scheme in Bhutan had been initiated by 1979, the beginning of training of such workers in most of the districts began only by mid '80s. By 1994, more than 1,000 VHWs were trained throughout Bhutan (Danida 2001). They were given an initial training of 12 working days followed by yearly refresher training of five days' duration (Namgyal 1994).

The basic training consists of ten modules covering the basics of preventive health (e.g. child health, nutrition, safer motherhood, family planning and sexual health), identification and treatment of minor illnesses, attending to injuries and guiding people to take timely action during sickness and other health needs (Government of Bhutan, 1996).

Incentives/motivation

As VHWs do not constitute a regular cadre and the services offered are voluntary, the VHWs do not receive any kind of financial benefit from the government, except during the training period when each VHW would receive a daily stipend at par with other sectors (Government of Bhutan, MOHE). The VHWs work in the community because they have been trusted and trained to care for the community and it gives them recognition for their service. Some VHWs see this recognition as a way of getting higher level community and block leadership (Sharma 2003, personal communication).

In Bhutan, it is a traditional practice to offer something to traditional and religious practitioners. The *Gewog Yargay Tschogchung* (GYT or Block Development Committee) decides upon a system of remunerative compensation for the time, effort and services rendered by the VHWs. Some communities have devised the ways of exempting them from contributing labor to local development work (Sharma 2003, personal communication). However, such an offer or contribution would be purely voluntary and should be acceptable to the VHW.

The other motive that drives the VHWs to continue is the central Buddhist tenet of service for the sake of improving ones "karma". Many VHWs tell that although they receive nothing for their service now, they feel that the good that they have done will certainly help shape a better "karma" for the next life. There is also a general attitude in Bhutan that responsibility delegated in some way has to be fulfilled. However, with modernization and increasing wants for this life, it is a debatable point and for how long can such a sentiment be sustained (Namgyal 1994).

Monitoring/follow up

According to the Ministry of Health and Education Strategy Paper, the VHWs' activities would be regularly supervised and routinely monitored by the respective GYT (Block Development Committee) and basic health unit (BHU) staff. VHWs would maintain simple records of the activities undertaken and submit reports to the BHU. The BHU staff would submit the reports of VHWs activities to District Health Supervisory Officers, who in turn would submit to the national program manager. The National Program Manager would be responsible for overall planning, implementation and evaluation of the VHW program and monitor all activities carried out by different *Dzongkhags* in the country.

With doctors scarce, Bhutanese turn to village health workers

*By Karma Singye Dorji
Feature No 00175.BHU, July 1996, in
<http://www.unicef.org/features/feat175.htm>*

.....Though VHWs do not provide routine checkups and immunizations, they do assist the mobile health units that make frequent visits to villages. They also provide health, hygiene and nutrition information that helps alleviate respiratory infections, poor nutrition, anemia and inadequate maternal health care - major causes of death and disease....

....Kencho Tshering, like other VHWs, knows a lot about prevention. Sitting behind his crude wooden desk, he dispenses advice about everything from safe water and household hygiene to birth spacing. His clients listen respectfully and nod their heads in solemn agreement. Surrounding them are brightly colored wall posters illustrating the diseases of childhood, the importance of immunizing children, nutrition tips and ways to keep toilets clean.

But watching over the health of so many people is a huge added responsibility for a man whose primary occupation is farming...

Mr. Tshering's age has a lot to do with the respect he receives in his traditional society, where advanced years are correlated with wisdom. Like many VHWs, Mr. Tshering has no formal education, yet he wields the authority of a professor, and a popular one at that. Though his services and government supplied drugs are free, his clients nevertheless heap him with small, thoughtful gifts. When he falls ill, they help with cooking and field work. And when he walks through the village, the men quickly put out their cigarettes in deference to his anti-smoking campaign.

Although, the government has follow-up guidelines, refresher training was found to vary as were supervisory practices. Most often VHWs meet at the outreach sites or come to the BHUs for monthly meetings (Danida 2001).

Replication/scaling up

Village health workers have been recognized as a positive force in the community at all levels, including the National Assembly. The 2003 Annual Health Conference, which was attended by VHWs, recommended sustaining and scaling up the VHW program. There is a great demand for VHW training from those communities which do not have VHWs, either, because no-one was trained before or, to replace the drop-outs. However, as the program is totally dependent on donors, even maintaining the network of close to 1,300 VHWs is becoming a challenge. In this situation, the only feasible option is to find ways of keeping the VHWs working and to continue refresher-training program to maintain their knowledge and skills and this is the direction the VHW program has opted for (Sharma 2003, personal communication).

Sustainability

There is no direct input from the Government into the VHW program except the supervision and support given to the VHWs through the decentralized health system. There is a very high attrition rate and there is no specific mechanism in place to prevent or decrease the high attrition rate.

Except UNICEF, there has been a gradual reduction of support for VHWs from development partners. The probable reason is that they are being perceived as "just another pair of hands" in providing health services. Without a very specific support from the Government or community and a shift in strategy, it may be very difficult to sustain the existing VHW network (Sharma 2003, personal communication).

Constraints/challenges

In 1993/94, UNICEF supported a study of the VHW program implemented by the Health Division, Ministry of Health and Education (MOHE). The evaluation had identified a number of problems related to selection of VHWs (uniform selection criteria and process), time needed to perform their functions, supervision (no opportunity for on the job training or any form of supervision), 'career' advancement (no scope), compensation and sustainability (Danida 2001). In order to respond to some of these issues, Health Division, MOHE developed a strategy paper for strengthening of VHW program in Bhutan where the selection criteria, incentives, supervision and monitoring system, training and retraining arrangements and roles and functions of VHWs were clearly laid out.

It was observed that the five year attrition rate for VHW in Bhutan was 50 to 55%. Individual districts had attrition rates ranging from 21% to 63%. The most common reasons given for the high attrition was that the work interfered with their personal work (70%), family pressure (12%), too hard job (9%) and there was nothing to be gained from it (6%). Given the Bhutanese nature of being indirect, it would not be surprising if the majority left as there was no remuneration and career prospect as a VHW, but did not want to put it so plainly (Namgyal1994).

Given the high attrition rate and increasing need for VHWs, priority attention needs to be given to problems related to this program. In some areas the situation has improved and attrition rates have decreased as a result of VHWs being released from volunteer service in the community as a form of compensation. Still the issues needing clarification include the policy for recruiting replacements for VHWs who resign (Danida 2001).

India

Following reports of successful experiments in the non-governmental sector with the community health workers (CHWs), the Indian government introduced a CHW Scheme across the country in 1977 envisaging "provision of health services at the doorsteps of villager" (Chatterjee 1993, Maru 1983). However, the names of the worker and the scheme changed over time - from CHW in 1977 to Community Health Volunteer in 1980 and Village Health Guides in 1981.

The Village Health Guide (VHG) Scheme was made 100% centrally sponsored under the Family Welfare Program until April 2002. In 2000-2001, a very high level review committee was established to study in details the entire scheme. The review committee looked at the work done by CHWs, their abilities and honorarium and sustainability issues. Based on this study recommendation, the government of India communicated to the state governments that the national government's funding will be discontinued starting April 2002 and the states were asked to run the scheme on their own, if they could mobilize the resources. However, with this change in financing arrangements, it is reported that no states are currently running the VHG scheme (Suresh 2003, personal communication).

Based on the available written documents and personal communication, this paper highlights on India's experiences and lessons learned on VHGs up to April 2002.

Maru (1983) summarized the following as the objectives of Village Health Guide scheme based on the various official pronouncements:

- a. To provide basic curative, preventive and promotive health care at the door-steps of the people,
- b. To involve rural people in the provision, monitoring and control of basic health services, to place "people's health in people's hand" and
- c. To create a resource person trusted by the local population who could provide a link between primary health centre and the local community.

The scheme included training of one community health volunteer for every village community comprising of 1000 population. As of 2000, about 323,000 VHGs were working through out India, under the government of India sponsored scheme (Government of India 2000).

Selection of VHGs

The community used to select one of its own members as the community health volunteer or the VHW. The most common procedure adopted for selection of VHGs was that Village Panchayats (village self-government councils) recommended two or three names to the primary health centre and a final decision made by a committee consisting of Medical Officer, Block Development Officer and the elected chairperson of the Block

Panchayat Committee. Although the selection was to be made in an open meeting of the total village council, in practice, most often, only a few important village leaders were involved in the selection.

As the men were the main targets of the family planning program in the 1970s and early 1980s, males were selected as VHGs. However, after 1986, realizing the importance and neglect of domiciliary maternal and child health services and fresh attention given to women as the main target for family planning, the policy was changed and attempts were made to phase out male workers and recruit females in their place. But the organized male CHWs brought political pressure and legal procedures initiated against their removal, paralyzing the scheme in most states (Chatterjee 1993). Until the end of the program, about 80% of the VHGs were male.

The national directives had laid out a few standards concerning the VHG profile: he was to live in the village, have minimal schooling and be willing to devote two to three hours a day to community health activities. He had to be acceptable to all the groups forming the community, and was not to be a member of any political organization. The selection procedure gave the primary health centre personnel the responsibility of enforcing the standards (Jobert 1985).

Roles of VHGs

The VHG was expected to know the health needs of the community and provide basic health services: minor treatments, preventive measures, including education and liaison with specialized health institutions (Maru 1983, Jobert 1985). He/she would receive a manual of instructions and a 'health kit' for his/her works as well as a small supply of medicine for first treatments. If the action required was beyond his/her skill or resources, he/she would draw on the resources of the formal health structure and in the process render it more responsive to community needs.

The VHG was expected to educate the village population about health problems, such as family planning or public sanitation and personal hygiene, which might not be perceived by the community members as their felt needs. AVHG used to be a change agent as well as a representative of the community (Maru et al 1983).

Training

After the VHG was identified and approved by the selection committee, he/she used to undergo through a three-months training in simple and basic health care at the primary health centre. During the training period, the community health volunteer used to receive from the government, a monthly stipend of Rs. 200. After the training, the VHG used to spend 2-3 hours a day for health work in his community (Maru et al 1983)

Incentives/motivation

The government used to provide an honorarium of Rs 50 per month plus basic medicines worth Rs 50 and both of these were disbursed to VHGs through the primary health centre (Maru 1983). Although, the government made it clear at the outset that the VHGs were volunteers and accountable to the communities they came from and served, communities viewed them as government employees because they were 'paid' a small monthly stipend. The health system personnel also perceived the CHWs as government employees and therefore, assigned them additional tasks.

Providing the stipend for each VHG was a sizeable recurring expense for the government. Therefore, in 1981, the central government had decided to reduce its contribution from 100 to 50 percent of the costs of the scheme and asked the State Government to meet the remainder. But, this led to several States backing out of the program. Later, following the conviction that women should be employed as VHGs, the central government decided to fund the scheme fully once again (Chatterjee 1993).

All this led to employment considerations becoming more important to VHGs than social service and ultimately they were demanding for higher remuneration. As a result, by 2001, there were at least 23 cases in various courts all over India demanding for raising the honorarium but all the cases failed as the court took a decision that being a volunteer scheme it did not stand well against the demand for increasing honorarium (Suresh 2003, personal communication).

Monitoring/follow up

The routine functions and activities of the VHG were supervised and controlled by the community. As he/she was not a government employee, there was no direct line relationship with the primary health centre staff. The local community could decide to change the CHV if he/she did not perform well after the training. But, in such cases, the community was expected to bear the cost of training the second VHG (Maru 1983).

Replication/scaling up

There is no plan of reviving the VHG scheme by government of India (Suresh 2003, personal communication)

Sustainability

Because of the failure of taking ownership of the program by the state governments and discontinuation of financial support from the central government, the VHG scheme ultimately came to an end after 25 years of running. There is a great lesson to be learned from this case about whether the honorarium to be given or not to CHWs if it can not be sustained as well as the importance of involvement and buy-in of the local governments (state governments in this case) and community support, from the very beginning of the program.

Constraints/challenges

VHGs in India had encountered a number of difficulties stemming from inadequate support from their communities and the health system alike. One of the main issues enveloping the VHGs was their 'medicalization'. Trained for three months, they focused on providing curative services, to the neglect of preventive and promotive tasks. This was due in large part to their orientation to curative care during their initial training which was conducted by Primary Health Centre doctors and Health Supervisors, who were themselves not instructed appropriately in how to train basic health workers.

The VHGs began to perceive themselves as village medical practitioners, often even demanding further training for this purpose. While village communities concurred because their perceived need was for curative services, they usually viewed the VHGs as "third class doctors", and bypassed their services whenever possible. At the same time, India's powerful medical lobby, the Indian Medical Association, opposed the scheme on the grounds that these workers would indulge in quackery, inflicting inferior or even dangerous care on underserved and unsuspecting villagers.

Poor role definition led to other difficulties in the scheme. VHGs were seen as extensions of the health system, especially to undertake family planning motivation and sanitation tasks.

Nepal

In Nepal, there are many forms of volunteer service and types of volunteers, including religious service volunteerism. Community members consider traditional birth attendants (TBAs), female ward members (political leaders), functional users group and committee members to be volunteers. In addition, there are many volunteer programs supported by national and international NGOs for health and family planning programs.

In the late 1970s, the Government of Nepal launched its first national Community Health Volunteer program. During the last 25 years, the volunteer program has evolved, changed and expanded into the current national Female Community Health Volunteer (FCHV) program, with more than 48,550 trained volunteers in all 75 districts throughout the country. (Government of Nepal and Maternal and Neonatal Health 2003, Government of Nepal 2003)

Since the implementation of the National FCHV Program in 1988, the context in which FCHVs have been involved in community health improvement has witnessed significant changes. The roles and responsibilities have continually evolved, the variety of different health programs utilizing community-based approaches has increased and Village Development Committees have begun to take local responsibility for the management of Sub Health Posts in accordance with the Local Self-Governance Act (Government of Nepal 2003).

Selection of FCHVs

The official criteria for selection of FCHVs state that in each ward (an administrative division with approx. 500 inhabitants) of Village Development Committees (lowest geo-political unit), one FCHV will be selected by local mothers' group (Curtale et al 1995). According to the national strategy, criteria for the selection of FCHVs are as follows (Government of Nepal 1992):

"The FCHV must be a local resident, willing and capable to work as volunteer, at least 20 years old and literate. If literate woman is not available illiterate women meeting other criteria may be selected. But such illiterate women should be willing to attend literacy classes.

Preference will be given to those involved in social works/health activities and married women with one or two children, and those who have completed primary education"

In recent years, some districts have implemented a population-based system, which varies depending on the population density: one volunteer for 400 population in the Terai, 250 in the hills and 150 in the mountains. However, this official criteria for selecting the FCHVs are currently being reviewed by the Family Health Division, Ministry of Health.

In a study on the concept of volunteerism (Government of Nepal and Maternal and Neonatal Health 2003), many community people observed favoritism in the selection of FCHVs. The overall impression was that selection occurs through informal networks and, therefore, the process was in the hands of local elites. The majority of FCHVs were described as being selected or appointed by Village Development Committee members, political leaders, local elites or health workers and many appointed volunteers were related to local leaders and health workers. Several community members complained about excluding women who were poorer and from "lower" castes and ethnic groups in the selection process. The exceptions were in those areas where NGOs have taken an active role in the formation of mothers' groups and adequate attention given in the process for selecting government supported FCHVs.

People who were active, educated, and with some connections were viewed as having the best chance of being selected. Most often FCHVs were not selected by the mothers' groups and in fact, it was reported that mothers' groups were often formed after the FCHV was selected.

Role of FCHVs

FCHVs played an important, multi-faced role related to family planning, maternal and neonatal health, child health and select infectious diseases (e.g. diarrhea, acute respiratory infections) at the community level. They promoted the utilization of available health services and the adoption of preventive health practices among community members. They were recognized as health educators and promoters, community mobilisers, referral agents and community-based service providers (Government of Nepal 2003)

The FCHV was expected to conduct mothers' groups meetings to discuss and teach health messages from her manual as well as use other opportunities to meet the mothers in groups or individually to discuss health messages and advise them for applying good maternal and child health and family planning practices (Government of Nepal 1992).

The study on the concept of volunteerism (Government of Nepal and Maternal and Neonatal Health 2003) noted that many community members and even some Village Development Committee officials were unaware of the responsibilities of FCHVs. The activities most frequently and consistently identified by the community members were those associated with national programs (e.g. Vitamin A distribution and polio campaigns). The national Vitamin A program (supported by the Nepal Technical Assistance Group) provided training and active supervision, clearly defined job responsibilities and training allowances for vitamin A. In addition, participation was required for only a few days twice yearly, rather than throughout the year, as were other FCHV responsibilities. Volunteers were described as being best able to carry out such clearly defined, concrete tasks, rather than activities such as health education.

However, community members expressed a preference for volunteers to provide treatment and distribute medicines, rather than health education. In the study on the concept of volunteerism, volunteers also said that they wanted to be trained to distribute medicines. Acute respiratory infection (ARI) program provided another good example of the community's positive assessment of the FCHV's role in distribution of cotrimoxazole. In the ARI program, volunteers had concrete tasks, were given good training and were closely supervised and monitored. In a study conducted in 1997 by Child Health Division, Ministry of Health Nepal on Assessment of ARI Strengthening Program, it was found that FCHVs were acceptable care providers to mothers, because they were easily accessible and gave

good advice. They were also seen as affordable and they gave good medicines. Especially, poor people and those living in remote areas greatly benefited from their services and for times when other care providers were not available like at night times (Government of Nepal 1997).

In the study on the concept of volunteerism, many volunteers and community members referred to the increasing burden of work and time commitment expected of volunteers. At central level, the people interviewed expressed concern that an increased burden could overwhelm volunteers and undermine their performance and the program.

Training

Training has been identified as the most important component of the FCHV program. The National Health and Training Centre developed the national guidelines for an initial training of 15 days, followed by refresher training for two days every 6 months. Usually, the initial training was organized in the nearest health facilities (health post or sub-health post) by Health Assistants, Assistant Nurse Midwives and Auxiliary Health Workers under the direction of the District Health Office. The initial training for FCHVs were focused on family health care with emphasis on motivation and health education in relation to immunization, diarrhea control, nutrition, hygiene, acute respiratory infection, maternal health and family planning. The training was primarily knowledge-oriented and not skills-oriented, except the specific training on integrated management of childhood illnesses (IMCI), community-based acute respiratory infection and control of diarrhoeal diseases, and Vitamin A deficiency disorders (Government of Nepal and Maternal and Neonatal Health 2003).

The study on concept of volunteerism noted that FCHVs were not given training on interpersonal communication, how to provide counseling, how to conduct meetings, or how to teach and present information - even though these activities were essential for performing many of the responsibilities assigned to FCHVs. The study also revealed that training was not regular in all areas and where it was more frequent, volunteers reported that it had become repetitive and ritualistic, with rote teaching methods most often used by local health workers. Some volunteers attended many different types of training sessions provided by

government and other organizations - the many types of training did not appear to be coordinated or prioritized. However, volunteers said that they liked training, and many expressed an interest in learning new things and they needed refresher training to be able to teach people in the community (Government of Nepal and Maternal and Neonatal Health 2003).

Incentives/motivation

Compensation or remuneration of CHVs continues to be an issue of intense debate in Nepal. The debate intensified in 1988 when the FCHV program was established and volunteers were given Rs 100 per month. Provision of this allowance could not be sustained and was discontinued after the first year, but is still remembered and discussed. The issue became complicated by the fact that there were several types of community-based health workers who were called volunteers and received payment from NGOs, but volunteers with the national health volunteer program did not receive a salary or financial compensation except for a daily allowance during training sessions.

Although volunteerism was described as being free service, there was a consensus among most of the people concerned (e.g. central and district officials, health workers, NGOs staff, community members and leaders) that FCHVs need to be remunerated or receive regular incentives. These could be in the form of financial allowances or non-monetary benefits such as bicycles, radios, saris etc. Such benefits were considered to have a positive influence on the family's willingness to give permission for women to serve as volunteers; improve the volunteer's status in the community; provide compensation for the time taken from household and agricultural responsibilities; and be an incentive for long-term service.

In addition to remuneration and incentives, community recognition and public appreciation for the contribution of volunteers in the form of awards, certificates, ceremonies, etc., was desired especially by volunteers. This recognition was identified by volunteers as an important factor in their own sense of satisfaction and motivation to continue as a volunteer (Government of Nepal and Maternal and Neonatal Health 2003).

Curtale et al (1995) noted that the role of FCHV that required them to deliver treatments (control of ARI and intestinal helminthes and oral re-hydration therapy) rather than just promoting utilization of available health services, seemed to have greatly increased their motivation level.

Monitoring/follow up

Village Health Workers were the primary contact and Village Health Workers were the primary contact and responsible government health cadres for supervision of FCHVs. However, the study on the concept of volunteerism (Government of Nepal and Maternal and Neonatal Health 2003) noted that supervision was not found to take place in many areas and in others it was irregular and informal, except for the national health programs, e.g. Vitamin A, polio immunization days, which were reported to provide regular supervision and some allowances for these activities.

The study report noted that most interactions with FCHVs took place at outreach clinics (ORCs) and often FCHV participation in ORCs was not regular and in some areas, the ORCs themselves were held irregularly. In addition, these meetings were brief and did not serve as a forum for guidance or problem solving. The health workers were not found to be providing much support for the volunteers.

According to the study, refresher training was described as the major form of supervision and for many these training sessions were the only events when they received supervision. It was also noted that supervision was difficult because FCHVs did not have a clear job description and were not paid. Questions were raised about the appropriateness of supervising volunteers. Contrastingly, some NGO supported volunteer programs, such as Family Planning Association of Nepal paid volunteers for specific tasks and targets, and provided supervision on the basis of their ability to carry out these responsibilities.

As a result of an index-control study conducted on improving skills and utilization of CHVs in Nepal, Curtale et al (1995) observed that increased number of supervision visits seemed to motivate the CHVs. Continuous supervision diminished the sense of isolation that CHVs usually experienced in the field and helped to sustain their interest and motivation to do their assigned tasks.

Replication/scaling up

The FCHV program has already been expanded to all 75 districts in the country. There is a plan for phased replacement of those who are now quite aged and of those who are inactive. The FCHVs' original role has been modified a great deal to include diagnosing, treating or referring cases of pneumonia, involvement in national immunization days, Vit. A distribution etc. As the IMCI strategy is implemented in more and more districts, demands on the FCHVs are increasing (Pratt 2003, personal communication). FCHV program has also been expanded to select municipalities.

Sustainability

Through orientations and review meetings, efforts were made to generate support from local government bodies and from communities in organising mother's group meetings, replenishing FCHV medicine supplies, disseminating information and providing incentives for FCHVs etc.

At present, 47 (out of 75) districts have established a district level endowment fund for supporting FCHV activities. This Fund needs to be activated and transferred into Village Development Committee (VDC) level endowment fund. There is a lot of interest and encouragement to the VDCs to sustain the FCHV program. Approximately 400 VDCs of 18 districts have already established endowment funds (Pratt 2003, personal communication).

Constraints/challenges

As noted above, among rural villagers there is a greater interest in curative services rather than health education. This was also reflected in an anthropological survey conducted in Nepal by Stone (1986). She concluded that in the villages she visited there was a social pressure to move the health workers away from the health education role and toward a community 'doctor' role. This pressure came from both the community people and the health workers themselves (Curtale 1995). CHVs reported frustration that, contrary to the expectation of their fellow villagers, they

were not really able to treat illnesses. When asked directly how the program could be improved, CHVs unanimously asked that they be given more medical training and more drugs.

Sri Lanka

In Sri Lanka, the involvement of school teachers and village/community leaders in voluntary work can be traced as far back as 1915, to the Rockefeller Foundation sponsored campaign for control of hookworm infestation. During the malaria epidemic of 1934/35, extensive involvement of voluntary workers was a special feature of the government's malaria control program while the non-government organizations began involving volunteers from the 1950s (Walt1989).

The main growth of the volunteer program however, was from the mid 1970s. Service organizations such as the Family Planning Association started to train volunteers in the 1970s, expanding from 60 in 1973 to 40,000 in 1987. Many other non-government agencies (e.g. Oxfam, Save the Children (UK and US), SIDA and JOICFP, a Japanese organization) also supported small volunteer programs. The largest trainer of volunteers within the government, however, is the Health Education Bureau, part of the Public Health Division of the Ministry of Health. From 1976 onwards, the Health Education Bureau developed its volunteer program and trained 100,000 volunteers (Walt et al1989). However, opinions differ on the current number of volunteers working regularly, with one conservative estimate being 15,000 (Country Health Profile at http://w3.whosea.org/cntryhealth/srilanka/sri_lanka2.htm).

Selection of CHWs

Based on a collaborative research study carried out in 1987, that reviewed policy and practice of national CHW programs in general, Walt et al (1989) noted that although volunteers were supposed to be chosen by the community to which they were accountable this seldom occurred. In the stated research, 136 health volunteers were studied and the majority of the health volunteers from both settlement and non-settlement study areas stated that they were recruited by health staff. In the non-settlement area, 91% had become health volunteers through their contact with the public health midwife (54% in the settlement areas). In the settlement

areas, other health volunteers and family members persuaded 26% of the health volunteers to take on the task. This method of selection was confirmed by the fact that 80% (96) households did not know how volunteers were selected. Gilson et al (1989) also confirmed that the recruitment and training of volunteers very heavily depended on the initiative of individual health professionals.

Role of CHWs

Harnessing the potential of educated young men and women in rural areas in order to provide continuity to the health communication messages, and contact between the community and health staff was a strong motivation for training health volunteers. Volunteers were originally conceived as having a broad role - as agents of development, spearheading community participation within their own communities, as well as being educators and communicators. Each volunteer had responsibility for ten or so households, and usually lived very close to them, but it was difficult to quantify the number and purpose of the visits because they were often extremely informal (Gilson et al 1989)

In the settlement areas the CHWs were given a small number of medicines which they replenished on a once-per-month trip to a nearby health facility. They carried stocks of aspirin, ORS packets, cicatrine for wounds and chloroquine and primaquine to treat malaria. These volunteers kept simple records, and during the malaria season might get 10 or more people per day, coming to them with fever which was assumed to be malaria.

In contrast, the non-settlement volunteers had no medicines and did not have a formal, regular meeting with health staff once a month.

Training

Walt et al (1989) reported that training was one of the main differences between volunteers from the settlement and non-settlement areas. In the settlement areas, the CHWs received a 3-month course of training whereas in the non-settlement areas they received a much shorter training up to 5 days. Although the Health Education Bureau had produced guidelines on volunteer training, it varied significantly from

place to place. Much of their learning was done in formal lectures by health personnel. According to Walt et al (1989), less than half the volunteers felt their training was adequate, while 63% of settlement volunteers were satisfied with their training. The need to develop communication skills was largely ignored and therefore, twenty percent of non-settlement volunteers felt that they needed to be taught methods of communication, so that they could transmit health messages more easily (Walt et al 1989, Gilson et al, 1989). General feelings of inadequacy led volunteers to want more training.

Incentives/motivation

From mid-1986 it was made clear that volunteers could be considered favorably for both public health midwife training, and unskilled employment in hospitals or other Department of Health positions. These statements marked a change in Ministry of Health policy in the sense that volunteers were publicly recognized and volunteering became a possible path to prospective employment.

In the study referred by Walt et al (1989), sixty percent of volunteers had put their main reason for volunteering as hoping this would lead to employment, and over half had already applied for jobs, not always in the health sector. However, over a third had put service to the community as their primary motivation for volunteering, and many volunteers gave multiple reasons which included self-improvement through further training. It seemed that the material expectations from volunteering were by no means the only forces driving people to volunteer, and that satisfaction was gained from helping others, especially where as in the settlement volunteers, they could offer material help.

"Officials come from outside and go away. We live here and see the hardships people undergo. They have to go 4-5 miles with a sick person sometimes. It is a great merit to relieve pain" - Quotation from Walt et al (1989)

Focus groups discussions with health volunteers in the above mentioned study confirmed another motive: that of liking to work outside their homes, to use otherwise idle time. The volunteer program gave young women an opportunity to work in an area which established their social recognition, legitimacy of their moving around the locality, and identification with relatively high status health professionals.

Monitoring/follow up

Although, the community members expressed some appreciation of the CHWs and some satisfaction with their services, community support was largely passive. Hence, the supervision of CHW depended heavily on the interest of family health workers who received no incentives for supervising volunteers (Gilson et al 1989).

Sustainability

The volunteer program depended crucially on the public health midwife's energy and interest for both training and day to day contact with volunteers. There were no material incentives for either health staff or volunteers. This means the costs for the program were extremely low and the sustainability of the program rested on contact with health staff, seminar programs, health exhibitions and so on (Walt et al 1989).

What are the Lessons Learned?

Most of the South Asian countries piloted Community Health Worker programs in late 1970s and based on the successful experiments in small-scale, these countries scaled up the program to national level by late 1980s. The experiences reviewed in the previous section show that no one model is perfect and would work for all the countries. Each country has learned its own lessons and witnessed significant changes in the modality and focus of the program during the course of program implementation e.g. continually evolved roles and responsibilities, increased responsibility of local governments, involvement in treating basic health problems etc. Except India, all countries reviewed are still continuing with the CHWs and have well integrated them into the national health services program. Overall, the following generic lessons are drawn from this review.

Selection of CHWs

Although all countries have had standard criteria for selecting CHWs that included involvement of community members in the selection process, most often the volunteers were appointed by local elites, political leaders and health workers and were related to these people. Given this situation and the fact that the ethnic minorities or marginalized and poorer groups in the community get excluded from the selection process, equitable involvement of community members in selecting CHWs and using their services appears to be critical to successful CHW programs.

Though the criteria for selecting CHWs could vary depending upon the local and national context, based on the successful examples, the generic selection criteria could include the following: selection by the community members equitably, married female (so the CHW would not leave the community) of 20 to 35 years from the same community, socially acceptable, preferably literate (so that they can record health information and use written materials), demonstrated involvement in and willing to work for the community. The evidence from India shows that involvement of local government in selecting CHWs and their buy-in from the beginning of the program is extremely important for having success.

Roles

Evidence shows that CHWs can be extremely effective to work as a complimentary force promoting utilization of available health services and the link between the community and the health system. However with regards to their roles, whether the CHWs should have a single or multiple focus, maintaining a delicate balance between the curative and preventive role seems to be of critical importance. The evidence from Nepal and Bangladesh shows that prevention is extremely hard to sell while curative care (treatment of ARI and other minor health problems) is generally more welcomed and appreciated by the community members.

Additionally, CHWs are best able to carry out clearly defined, concrete tasks over a short and specific time period such as national health campaigns (Vitamin A distribution, polio campaigns etc) rather than carrying out broad-based activities such as health education. One should also take into consideration that increased burden of work and excessive time commitment for multiple tasks could overwhelm volunteers and in turn, negatively affect their performance and the program.

Training

All the countries reviewed had provisions of basic foundation training that ranged from five days to three months, and refresher training (one to five days) in regular intervals. Most often, the basic training focused on preventive health, health education and first- aid. It would be a formal lecture based and knowledge-oriented training rather than the one which is skills-oriented and community specific or contextual.

The review of the CHW literature revealed a strong need for the training in interpersonal communication and counseling skills, including methods of adult participatory learning. It also noted that continuous training is found to be an essential prerequisite for an effective CHW program and an important factor in retaining their motivation level.

Incentives/motivation

Except India, all countries reviewed did not pay salaries or provide any kind of monetary incentives to CHWs, because the governments did not

consider the salaries to be sustainable. Although Nepal started with a provision of small allowance per month (less than \$2), it was discontinued after the first year as this could not be sustained. However, they were paid nominal allowances during the training period in all countries.

Contrarily, countries are encouraging communities and local governments for providing them either monetary or, non-monetary incentives such as bicycles, radios or community recognition and public appreciation for the contribution of volunteers in the form of awards, certificates etc. And, some communities have even set up special funds for supporting the CHWs (e.g. Nepal).

Ideally speaking, it is said that service to the community as the primary motivation factor for volunteering. However, it is reported that training stipend, earning an income through selling medicines and possibility of future employment opportunities are the motivational factors for many CHWs. But, evidence has shown that monetary incentives often bring a host of problems: money may not be enough, may not be paid regularly or may stop altogether (e.g. Nepal and India). Hence, non-monetary incentives are critical to the success of any CHW programs. Additionally, the role of CHW that required them to deliver curative services rather than just promoting utilization of available health services seems to greatly increase their motivation level.

Monitoring/follow up

Although community members express some appreciation of the work of CHWs and some satisfaction with their services, often community support is largely passive. Monitoring and follow up of CHW is seldom done by communities. It largely depends upon the initiative and interest of the government health workers at periphery level, who receive no incentives for supervising the volunteers. Hence, in reality, the interactions with CHWs usually take place at the out-reach clinics or refresher training which are held irregularly.

The evidence from the field shows that regularity of supportive supervision and appropriate refresher training helps to sustain the interest and motivation of CHWs to do their assigned tasks (e.g. Bangladesh and Nepal). Similarly, frequent interactions of community members and CHWs are also critically important in affecting their motivation levels.

Replication/scaling up

In most of the reviewed countries, the CHW approach has "gone to scale" based on the results, real and perceived, of the small-scale pilot projects. These pilot projects had demonstrated that with intensive support, CHWs can provide effective interventions of adequate quality, coverage and equity to achieve significant reductions in mortality and associated improvements in health status. Particularly, analysis of Bangladesh's experience suggests that several factors are essential for successful scaling-up. They are qualified, experienced and dedicated human resource base to support the program, effective management systems including monitoring and evaluation systems, learning environment (encouraging learning from interaction with the field) and adequate financial support.

Sustainability

A basic lesson from this review is that CHWs must be adequately supported and such adequate support requires more resources from the government or communities than what are spent now on CHW programs. CHWs cannot be seen as a marginal addition to existing services funded by limited one-time special expenditures. Evidence from Bangladesh suggests that the level of institutional support in training and retraining, program management and supportive supervision by health workers greatly determine the sustainability of the CHW scheme. By developing strong, better educated and empowered women and village groups, sustainable improvements can be achieved and a higher quality of preventive health measures will be practiced in the community.

Constraints/challenges

The major issues identified are related to selection of CHWs (community involvement, uniform selection criteria and process), time commitment and workload, communities' preference for curative services, remuneration/incentives (continuity, source, uniformity), prospect for career advancement and high attrition rates etc.

The evidence shows that from the very beginning stage of the program, clarity on community role, selection criteria, CHWs' role, mechanisms for compensating CHWs' time involvement and incentives, together with adherence to these basic principles helps to enhance the effectiveness of the CHW program.

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