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Country Report for Bangladesh

Evaluation of South Asia's Current Community Health Worker Policies and System Support and their Readiness for Community Health Workers' Expanding Roles and Responsibilities within Post-Astana National Health Care Strengthening Plans

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Content

Acronyms

AHI	Assistant Health Inspector
ANC	Antenatal Care
BCC	Behaviour Change Communication
CBHC	Community-based Health Care
CHCP	Community Health Care Provider
CC	Community Clinic
CG	Community Group
CSG	Community Support Group
CHW	Community Health Worker
CMNH	Centre for Maternal and Newborn Health
CPD	Continuing Professional Development
CPR	Contraceptive Prevalence Rate
CHS	Community Health Supervisor
DGFP	Directorate General of FP
DGHS	Directorate General of Health Services
FPI	FP Inspector
FWA	Family Welfare Assistant
GBV	Gender Based Violence
GoB	Government of Bangladesh
CSBA	Community Skilled Birth Attendant
HA	Health Assistant
HI	Health Inspector
HNPSP	Health, Nutrition and Population Sector Programme
INGO	International Non-Governmental Organization
KI	Key Informant
KII	Key Informant Interview
LSTM	Liverpool School of Tropical Medicine
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare Health
MPHV	Multi-Purpose Health Volunteer
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization

OP	Operational Plan
PHC	Primary Health Care
PNC	Post-Natal Care
PPHCC	Provincial Public Health Coordination Committee
PK	Pusti Karmi
RCHCIB	Revitalization of the Community Health Care Initiatives in Bangladesh
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
ROSA	Regional Office for South Asia
SBA	Skilled Birth Attendance
SDG	Sustainable Development Goals
SS	Shasthya Shebika
SK	Shasthya Kormi
UHC	Universal Health Care
UNEG	United Nations Evaluation Group
UHFWC	Union Health and Family Welfare Centres
WHA	World Health Assembly
WHO	World Health Organization

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Executive Summary

Introduction and background

The Astana Declaration of 2018 reaffirmed the importance of Primary Health Care (PHC) in achieving Universal Health Coverage (UHC) and the health-related SDGs. Community Health Workers (CHW) are the backbone of PHC. Evidence highlights their effectiveness in delivering a range of preventative, promotive and curative services. In the South Asian context of ongoing demographic and epidemiologic changes, there is an urgent need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post-Astana goals and commitments in the region.

To understand the CHW policies and system support in place to promote the effective functioning of CHW programmes, and to determine the key policy adjustments and interventions needed to address any gaps, a formative evaluation was conducted of CHW policies and systems support in South Asian countries. The evaluation also assessed the readiness of CHW programmes for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans.

For Bangladesh, the LSTM team, in consultation with UNICEF ROSA and the UNICEF Bangladesh Country Office, confirmed that there were seven CHW cadres active in the country and that these cadres would be covered by this evaluation. The principal CHW programmes of the Government of Bangladesh (GoB) are under the two directorates within the Ministry of Health and Family Welfare, which employ CHWs as part of their health workforce – the Family Welfare Assistant (FWA) under the Directorate General of FP (DGFP), and the Health Assistant (HA), the Community Health Care Provider (CHCP), and the Multi-Purpose Health Volunteer (MPHV) under the Directorate General of Health Services (DGHS). In addition, two cadres- sasthya karmi and pushti karmi, supported by BRAC – were identified and included in the list of current CHW cadres active in the country.

Objective, methodology and intended use of the evaluation

The overall objective of the evaluation is to understand the congruence between the current profiles, policy framework and system support for CHWs, especially those involved in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) programmes, and the profiles, policy framework and system support required to better serve RMNCAH, and to respond to PHC reform and strengthening in seven South Asia countries, including Bangladesh.
The findings will inform national government plans and

enhance UNICEF's and partner's advocacy and technical guidance to local governments that are instrumental in PHC priority setting, resource mobilization and allocation and the recruitment of the PHC workforce, including CHWs under national decentralization policies.

The evaluation responds to the following three key evaluation questions (KEQ):

- **KEQ 1:** What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?
- **KEQ 2:** What policy and system support improvements are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or Primary Health Care (PHC) reforms and strengthening.
- **KEQ 3:** What prioritized measures can be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?

Bangladesh has a pluralistic system with four key actors: government, private sector, non-governmental organizations (NGOs) and donor agencies. It has gone through a number of reforms in recent years. An extensive health infrastructure has been established in the public and private sectors, and there have been significant improvements in a number of health indicators, including under-five mortality, immunization coverage, maternal mortality and total fertility. Women's education, economic conditions and life expectancy have also improved. However, poverty and income inequality remain persistent challenges. The health system continues to face challenges to achieving UHC.

Methodology

The evaluation used a mixed methods approach for this evaluation that combined a desk review and key informant interviews. The review examined available national policies, plans and strategies, country reports, peer reviewed publications, reports from donors/development partners, international and local NGOs, evaluation reports, training guidelines, and CHW databases. In addition, qualitative data, was collected through interviews with national level key informants (KIs) involved in the CHW programmes A total of 23 KIIs, including three gender-focused KIIs, were conducted in Bangladesh between 20 and 28 October 2019.

A semi-structured topic guide and a gender-specific guide, informed by the evaluation framework and analysis plan, were used to collect data. Analysis used NVivo Version 11 based on: the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018), the health system building blocks (WHO, 2007), PHC levers (WHO/UNICEF, 2018), the WHO Gender-responsive Assessment Scale (WHO, 2011), and the Steege et al (2018) conceptual framework.

Findings

1. Current CHW profiles, roles and responsibilities, policies and systems support

Current CHW profiles and roles and responsibilities

Bangladesh has a long history of CHW programmes effectively contributing to the attainment of public health goals.

There are close to 185,000 CHWs in the country currently, with 70,000 of these employed by the government. This translates to 3.8 CHWs per 10,000 population.

Key policies and policy environment for CHWs

Bangladesh introduced the Community-based Health Care (CBHC) programme in 1998, and the Revitalization of the Community Health Care Initiatives in Bangladesh (RCHCIB) was introduced in 2009. Under this programme, over 13,000 community clinics were established to extend PHC to the doorsteps of rural people, enabling access for all to essential primary health services, and ensuring no one is left behind. This community-based health care programme is incorporated into mainstream health sector programme, with its own operational plan (OP) and budget under the current Fourth Health, Nutrition and Population Sector Programme (HNPSP).

The GoB has formulated a number of policy documents related to the health workforce in the public sector in recent years including an Action Plan of Bangladesh Health Workforce Strategy, and in 2019, a National Strategy for Community Health Workers. While the CBHC approach remains very relevant, its effectiveness has been constrained by the fact that the leadership of the government CHW programmes is provided through two separate directorates in the ministry, affecting coordination on the ground between health officials and providers as they operate in vertical silos.

CHW roles and responsibilities and focus on RMNCAH

The focus of CHWs' roles and responsibilities has always been on different aspects of RMNCAH service provision. Community Clinics (CC) are the lowest level of facility providing primary care services and are served by three cadres of CHWs posted there – the CHCP, HA and FWA. Each CC, with one CHCP, is expected to cover a population of 6,000. HAs and FWAs complement these CC-based services through the provision of domiciliary and community-based care. The MPHV cadre is primarily at the community and domiciliary levels. Each CC is expected to have five MPHVs, with each MPHV assigned to 250–300 households.

Several challenges affecting the ability of these CHWs to effectively carry out their roles and responsibilities were identified. These include overburdening of FWAs and HAs

with additional responsibilities, coverage of a larger population than mandated, lack of focus on preventative and promotive care, lack of accountability mechanisms, the emerging burden of NCDs, lack of sustained political commitment to community-based health services, and lack of coordination between different cadres.

Selection, education and certification

The FWA, HA, and CHCP are all selected through formal government recruitment processes. Criteria for selection include educational qualifications – both FWAs and HAs need to have passed eighth grade, and CHCPs need to have undergone 12 years of schooling. FWAs are traditionally female, while HAs are male. Both male and females are recruited as CHCPs. The Multi-Purpose Health Volunteer is female and expected to be from the local community; preferably selected from within the Community Group (CG) and the Community Support Group (CSG). There is no community engagement in the process of selection of any of the CHWs.

FWAs and HAs receive three weeks' training focusing on FP methods and immunization respectively. CHCPs receive 12 weeks' training, while MPHVs receive three days' training. Refresher training for government CHWs does not seem to be regular.

Challenges reported in the selection and training process include administrative constraints like ongoing court cases affecting recruitment, lack of coordination between government and NGO programmes, and a need for more regular refresher training.

Management and supervision

FWAs and HAs are permanent government staff on the government payroll, receive regular government salaries, and are eligible to receive benefits. However, pay is low for these cadres and is a source of low morale. The CHCPs are considered project staff employed through a trust created for the CBHC programme and are not permanent government employees, a source of dissatisfaction among them. The MPHVs are contracted on an annual basis and receive monthly performance-based incentives. There is a lack of a career ladder for all government CHWs.

There is a clear hierarchal supervisory system, with FP Inspectors and Health Inspectors supervising FWAs and HAs respectively. CHCPs are supervised by Upazilla level authorities on administrative issues and by Sub-Assistant Community Medical Officers (SACMO) and medical officers on technical issues. However, several challenges related to supervision were identified including poor quality of supportive supervision, lack of support for supervisors, and gender disparities between supervisees and supervisors affecting quality of supervision.

Integration into and support by the health system and the community

CHWs are well integrated in the health system through the network of community clinics all over the country. However, the complete exclusion of urban areas from the CHW programmes is a major challenge.

Individual CHWs receive supplies of medicines and commodities from the upazilla level, which in turn is supplied through a streamlined government procurement and supply system. Supply is usually adequate and stockouts are infrequent and minimal.

All CHWs collect data to feed into different levels of the HMIS. However, there are several challenges with the data management system, most importantly, lack of harmonization and integration of different systems.

While there does not seem to be any formal community engagement mechanisms or spaces for FWAs and HAs, such mechanisms have been set up for the CCs. The deployment of HAs and FWAs, historically domiciliary service providers, to the CC, seems to be compromising community-based service provision, especially in hard-to-reach areas where these populations have limited access to facility-based care.

Private sector involvement in CHW programmes

The for-profit private sector does not provide any preventative and /or promotive services, focusing on curative services. The not-for-profit private sector, such as NGOs, run their own CHW programmes.

Financing for CHW programmes

Financing for the government community-based programmes comes largely from domestic resources, with development partners providing funding for the overall health sector through the Health, Population and Nutrition Sector Programme 2017-2020 (HPNSP). The recruitment of additional CHWs to fill existing CHW vacancies and address shortages in the community clinics will need additional finances.

2. Prioritized measures to optimize the contribution of CHWs to respond to post-Astana requirements and PHC strengthening

Policy support measures

While Bangladesh has not articulated any specific post-Astana commitments, its health policies and strategies are focused on achieving UHC and the SDGs. The optimization, harmonization and re-envisioning of CHW programmes and the role CHWs can play in achieving these goals is a key focus of ongoing health policy discourse at the highest level and is articulated in the recently developed National Strategy for CHWs.

Harmonization at policy and programme level

There is an urgent need to harmonize the existing CHW workforce, especially at policy level, including harmonization of the different CHW cadres across government and NGO programmes. Towards this, the National Strategy for Community Health Workers recommends the creation of uniform geographic catchment areas for the different CHW programmes and teaming up male and female CHWs cadres, so that CHWs working in the same area can provide complementary and integrated services.

Recognition for CHW contributions

Including CHW cadres in human resources for health plans and budgets will recognize and enhance the potential contributions of CHW programmes to the overall health system and PHC in particular. Collaborative and collective action is needed to assess the health system and the health workforce as a whole, from the tertiary to the community level.

Strengthening comprehensive PHC

To achieve the SDGs, the government needs to re-envision the health system to create a comprehensive primary health system focusing on an essential services package and the human resources required to deliver such a package.

Addressing diverse and differential needs

A one-size-fits-all policy approach is not appropriate for Bangladesh, given its geographical, contextual and cultural diversity, and diverse models of service delivery will need to be explored. However, the provision of community-based health services across the country remains critical, especially for promotive and preventative services.

Establish urban health systems

Establishment of an urban PHC/UHC strategy would ensure the availability and deployment of CHWs with the appropriate skills mix to these areas and is urgently needed.

Coordination with NGO programmes

The government CHW programmes could work with NGOs and development partners to design and deliver innovative, high impact, quality maternal and newborn health in order to reach populations in the hard-to-reach areas.

Ensure adequate financial commitment

Long-term commitment and investment will be required to mobilize and invest the necessary financial and human resources to implement the National Strategy for CHWs over the long term.

Strengthen political commitment to address gaps

There is a need to acknowledge the strengths and the gaps in the current PHC system, especially around governance, efficiency, accountability, and then make the necessary political commitment to reform the system and address these constraints.

Integration of gender into all programmes

While gender figures at a macro level in policy documents, it needs to be further integrated into programmes, spelled out in operational plans, with a gender focus incorporated into each stage of the project cycle, and gender-specific indicators developed to monitor outputs and outcomes, and evaluate effectiveness and impact

3. System support improvements to optimize CHW cadres

Optimizing CHW workload

To reduce the burden on CHWs, action on a number of areas are required, including addressing the high level of CHW vacancies, revisiting the mandated target populations that CHWs are expected to cover, the expansion of their responsibilities, and using the MPHVs to increase coverage.

Strengthen supportive supervision

Measures to improve supervision including appropriate supervisor-supervisee ratios, adequate training for supervisors, and the use of observation, performance data and community feedback are needed to strengthen supportive supervision.

Strengthen community engagement and ownership

Given the importance of community engagement, the expectation for clinic time verus time in the community for FWAs and HAs needs to be reviewed. Greater community participation in the selection of CHWs, involvement in priority setting for CHW activities, the monitoring of CHWs, and in planning and budgetary processes would also be critical.

Improve accountability

Accountability was identified as a key area affecting CHW performance, and while community-based mechanisms could lead to improvements in this area, lack of accountability is also a larger organizational culture issue and needs to be tackled through interventions at multiple levels.

Harmonizing information systems

The lack of coordination between the multiple information systems used by the different CHW cadres and the resultant double counting and duplication of data is another challenge. The development of a system where each woman/client is given a unique ID is a way to more effectively track individual clients and harmonise the data collected.

Making CHW programmes gender-transformative

Suggestions towards this include gender training for CHWs to enable them to address gender and social inclusion issues in their communities, ensuring health and safety of health workers, addressing issues of gender pay gap and equitable renumeration, providing CHWs with career progression opportunities, increasing representation of women CHWs in leadership positions and roles, ensuring that gendered needs of women are considered in health workforce policies, and collection of gender-sensitive health data.

Recommendations

Recommendation 1: It is recommended to assess the health system and the health workforce as a whole, from the tertiary to the community level, and to create a more functional health system at all levels that responds to the needs of the population and enables the country to achieve UHC. The re-envisioning would focus on an essential services package and the human resources required to deliver such a package, rather than organizing the health system and the health workforce around specific diseases or programmes.

Recommendation 2: Efforts should be made to harmonize the different CHW cadres across government and NGO programmes. One way is to map the different CHWs and their roles and responsibilities in service provision, which would help identify the areas covered and the gaps that need to be addressed.

Recommendation 3: Efforts should be made to reduce the burden on CHWs. For this, action on a number of areas are required such as: addressing the high level of CHW vacancies; revisiting the mandated target populations that CHWs are expected to cover, and using the MPHVs to increase coverage; scale up MPHVs so that they take on some of the roles and responsibilities undertaken by the FWAs and HAs; create a pool of CHCPs based at divisional level.

Recommendation 4: Management, monitoring and supervision should be strengthened, as well as recognizing and rewarding good performance of CHWs should be initiated to motivate them.

Recommendation 5: Gender should be further integrated into programmes, spelled out in operational plans, with a gender focus incorporated into each stage of the project cycle (design, planning, implementation, etc), and gender-specific indicators developed to monitor outputs and outcomes, and evaluate effectiveness and impact. Gender has to be cross-cutting across ministries, it cannot be seen as the purview of the Ministry of Women and Children only.

Recommendation 6: Sexual harassment policies should be developed and implemented. Such a policy is not yet in place, in spite of a court judgement that ruled committees should be in place at the different levels.

Recommendation 7: Consider gender pay gap and equitable renumeration. Women's unpaid caring work needs to be formally recognized and valued to break the harmful gender norms that assume women are easier and cheaper to hire and that the women's labour is more pliant.

Recommendation 8: Provide CHWs with career progression opportunities: Policies need to consider how gendered responsibilities may make it difficult for women to relocate, which affects their career trajectory. Career development opportunities need to be built into the system of CHW programming to encourage women to progress into

higher levels of the health system and leadership positions if they so desire.

Recommendation 9: **Increase women's representation in leadership positions and roles:** Arguably, male and female CHWs are leaders within their own community. However, evidence shows that female CHWs are less likely to advance into decision-making positions as leadership roles are often reserved for men (C. Campbell et al., 2009; Newman, 2014; Sen and Ostlin, 2008).

Recommendation 10: **HR policies should consider the gendered-specific needs of women and men.** Workplace policies need to be put in place that support women in balancing paid employment and the domestic roles that disproportionately fall upon their shoulders. In addition, measures like maternity leave and sickness pay can help female CHWs to stay in employment.

Recommendation 11: **Overall measures such as improving the agency of women through interventions in schools, adolescent clubs, etc. are needed.** These may include the provision of restrooms and breastfeeding rooms for women in health facilities and ensuring health workers are more gender-sensitive. Health and community-based services should be more gender-responsive and more women-friendly, for example, more or an equal number of beds for women in general wards, separate queues for women, separate toilets, separate waiting spaces, and adequate privacy, will reduce barriers and constraints to them seeking care.

Recommendation 12: **Health management information systems should identify and highlight the gendered dimensions of health outcomes.** Gender-sensitive HR data should be collected, analysed and used, including undertaking an inventory and headcount of all CHWs, disaggregated by sex, location, seniority, and qualifications to address inequities related to gender, social inclusion and disability.

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Introduction and background

Country context

Bangladesh is one of the world's most densely populated countries. Health and education levels are relatively low, although they have improved in recent years as poverty levels have decreased. Most Bangladeshis live by subsistence farming in rural villages. Bangladesh faces a number of major challenges, including poverty, corruption, overpopulation and vulnerability to climate change (WHO, 2015). Bangladesh has made notable progress in reducing poverty, supported by sustained economic growth. Based on the international poverty line of $1.90 (using purchasing power parity exchange rate)[1] a day, poverty rates reduced from 44.2 per cent in 1991 to 14.8 per cent in 2016/173.

In parallel, life expectancy, literacy rates and per capita food production have increased significantly. Progress is underpinned by steady growth in GDP, which was around 7.9 per cent in 2018. This is coupled with the changing demographic profile of the country, which is moving towards an increase in working age population in the 20-34 age group. Rapid growth enabled Bangladesh to reach lower middle-income country status in 2015. In 2018, Bangladesh also fulfilled all three eligibility criteria for graduation from the UN's Least Developed Countries (LDC) list for the first time, and the country is on track for graduation in 2024.

The health system of Bangladesh is a pluralistic system with four key actors: government, private sector, non-governmental organizations (NGOs) and donor agencies. It has gone through a number of reforms in recent years, an extensive health infrastructure has been established in the public and private sectors, and there have been significant improvements in a number of sustainable development goal (SDG) related health indicators including under-five mortality, immunization coverage, maternal mortality and total fertility. Women's education, and economic conditions and life expectancy have also improved. However, despite recent economic growth, poverty and income inequality remain persistent challenges for the country.

[1] Based on poverty rates sited by World Bank

In 2014, the Climate Change Vulnerability Index ranked Bangladesh as most vulnerable to the adverse impacts of climate change.[2] In addition to being vulnerable to climate change, low access to reliable and affordable power, poor transportation infrastructure, limited availability of serviced land, uncertain and complex business regulation as well as rapid urbanization have critically challenged Bangladesh's progress.[3]

The health system continues to face challenges to achieving UHC. These include a lack of coordination between the two ministries implementing PHC service delivery in rural and urban areas, a critical shortage of trained health providers and skill-mix imbalances in the public sector, and inequitable access to health services between urban and rural areas (WHO, 2015). The need for increased domestic financing and investment, and more effective local accountability are acknowledged as critical to improving the quality of health services. The above context and status of SDGs affect the implementation of CHWs and their subsequent performance.

Specific Linkage to the SDGs: The SDGs call for an accelerated return to principles of a more holistic PHC approach. This evaluation is more directly related to the following SDGs. SDG 3: Ensure healthy lives and promote well being at all ages; SDG 5 "Achieve gender equality and empower all women and girls." The WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes, which was the key framework for the study, also notes that "policy and investment decisions on health workers have broader implications on several other targets of the SDGs, including job creation, economic growth, gender empowerment and education."

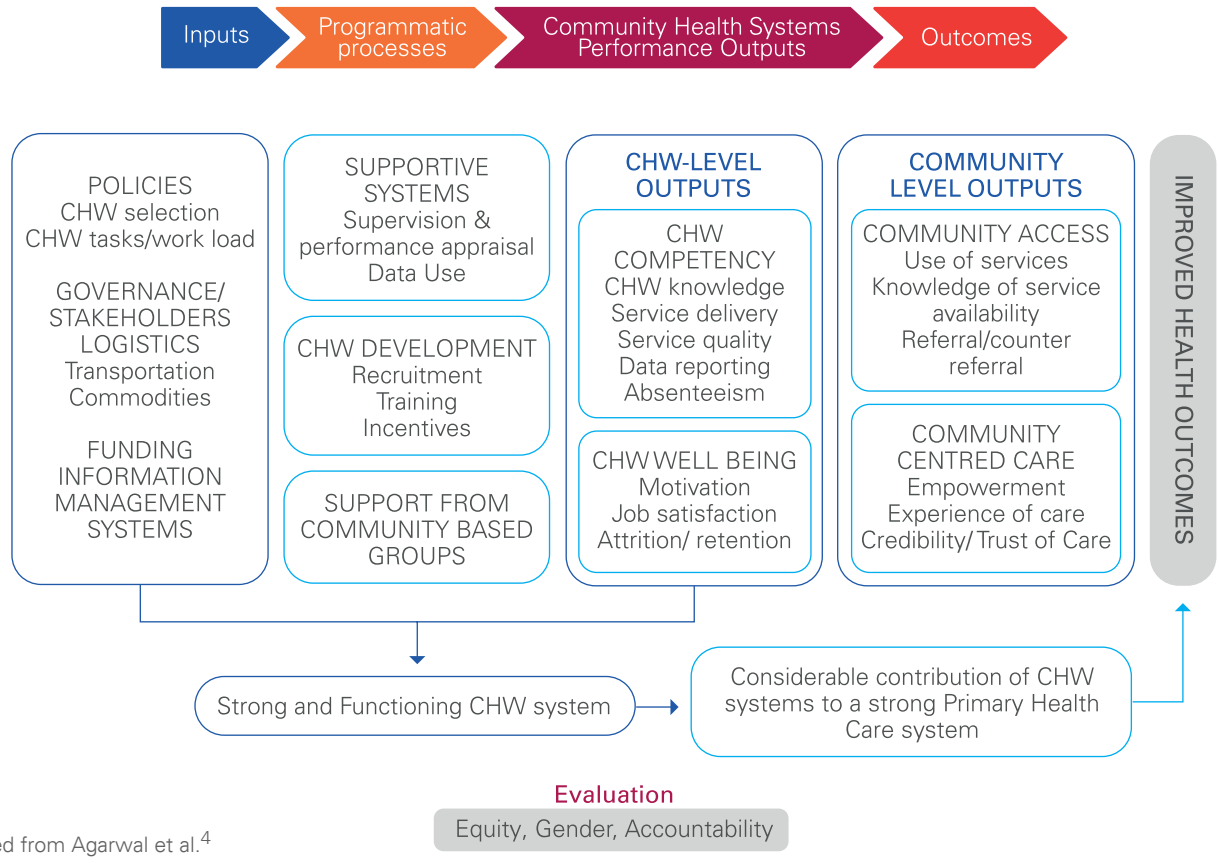
Object of the evaluation

In 2018, the Astana Declaration reaffirmed PHC as the most inclusive, effective and efficient approach to enhance people's health and set PHC as the route to UHC and the health-related SDGs. In this context, CHWs play an important role in advancing health protection and promotion and timely care seeking at PHC level. Part of this declaration focuses on strengthening the PHC health workforce and thereby CHW programmes.

The Astana Declaration envisioned the following:

1. Governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;
2. PHC and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;
3. Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being; and
4. Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

Figure 1: Illustrative Theory of Change for CHW programme



Adapted from Agarwal et al.[4]

[2] Retrieved from https://www.maplecroft.com/risk-indices/climate-change-vulnerability-index/

[3] 7 Retrieved from https://wess.un.org/wp-content/uploads/2016/06/WESS_2016_Report.pdf

[4] Agarwal et al., A conceptual framework for measuring community health workforce performance within PHC systems, Resources for Health (2019) 17:86

Relevant Theory of Change

While the evaluation is not theory-based, the WHO Guideline on Health Policy and System Support to optimize CHW programmes, which was the key framework for the study, organizes the contribution of CHWs to PHC around three broad areas: 1) selection, education and certification of CHWs; 2) management and supervision of CHWs; and 3) integration into and support by health systems and communities. The assumption is that with the necessary policy and system support related to these broad areas (i.e. supportive policies, investment, quality education, supervision and management systems and improved integration of community health into formal health systems), there will be improved contribution of CHW programmes to PHC strengthening. Governance, investment (financing), and monitoring and evaluation are also key to ensure that these investments lead to expected improvements in PHC service provision and health outcomes.

There is a need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post-Astana goals and commitments. It is, therefore, important to understand the CHW policies and system support that are in place to support the effective functioning of CHW programmes, and to determine the key policy adjustments and interventions needed to to help existing CHW cadres' transition into effective contributors to RMNCAH and to the PHC of the future in these South Asian countries, including Bangladesh.

To contribute to knowledge generation in this area, the Centre for Maternal and Newborn Health (CMNH) at the Liverpool School of Tropical Medicine (LSTM) has been commissioned by the UNICEF Regional Office for South Asia (ROSA) to conduct a formative evaluation of CHW policies and systems support in South Asia's, and their readiness for their expanding or changing roles and responsibilities within post-Astana national health care strengthening plans. This evaluation covers the eight South Asian countries that fall under the remit of UNICEF ROSA (Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka) and assesses CHW policies and system support at national level only.

One of the initial activities of the evaluation was a desk review, for which the LSTM evaluation team reviewed relevant peer-reviewed and policy documentation, focusing particularly on CHWs programmes with a focus on the provision of RMNCAH services. A key output of the desk review was the mapping of the available CHW cadres in each of the eight countries, which was then shared with and validated by stakeholders in each of the countries, including the UNICEF country offices.

CHW in Bangladesh, right holders and duty bearers

For Bangladesh, the LSTM team, in consultation with UNICEF ROSA and the UNICEF Bangladesh Country Office, confirmed that there were a total of seven CHW cadres active in the country and that these cadres would be covered by this evaluation, These cadres, which included those employed and supported by GoB as well as those supported by local NGOs, are presented below.

Currently, Bangladesh defines a CHW as follows:

A CHW is a permanent resident of a particular community, assigned by government/non-government organization, who provides promotive, preventative, limited curative care, rehabilitative, palliative and referral services in relation to maternal, neonatal, child and adolescent health, FP, nutrition, communicable and non-communicable diseases to his/her community and shall be held accountable for the non-performance of these services. (MoHFW 2019)

Table 1: Categories of CHWs supported by the government and NGO

No.	Employed/supported by GOB	No.	Supported by NGOs
1.	Health Assistant (HA)	1.	BRAC Shasthya Shebika (SS)
2.	Family Welfare Assistant (FWA)	2.	BRAC Newborn Health Worker*
3.	Community Health-Care Provider (CHCP)	3.	Community-based Skilled Birth Attendant**
4.	Multi-Purpose Health Volunteer (MPHV)	4.	Shasthya Kormi (SK)***
		5.	Pusti Karmi (PK)***

*Although the BRAC Newborn Health Worker was initially validated by stakeholders in Bangladesh as one of the key cadres, during the field visit, the KIIs and the data analysis it became apparent that this cadre was no longer active in the country.
** There are few Community-Based Skilled Birth Attendant in the country. Most work for NGOs or private agencies in Sunamganj district, and there was little reference to this cadre in the KIIs
***An additional two cadres were identified during the KIIs and the field visit, namely the Shasthya Kormi and the Pusti Karmi, both of which are supported by BRAC, and these were included in the list of current CHW cadres active in the country.

This is somewhat different from the WHO definition adopted by the evaluation team for this study as follows:

CHWs are *"health workers based in communities (i.e. conducting outreach beyond PHC facilities or based at peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours." (WHO 2018)*

The GoB's principal CHW programmes are under the two directorates within the Ministry of Health and Family Welfare. These include the Directorate General of Health Services (DGHS) and the Directorate General of FP (DGFP), which employ CHWs as part of their health workforce. The Community-Based Health Care Programme (CBHC) under the DGHS has a network of Community Clinics (CC), which are the lowest level facility providing PHC services and are staffed by CHWs.

While Bangladesh has not articulated any specific post-Astana commitments, its health policies and strategies are focused on achieving UHC and the SDGs. The optimization, harmonization and re-envisioning of CHW programmes and the role CHWs can play in achieving these goals is a key focus of ongoing health policy discourse at the highest level. These principles are articulated in the recently developed National Strategy for Community Health Workers, which affirms Bangladesh's commitment to the PHC approach, as reiterated in the Astana Declaration, and the key role envisaged for CHWs in the delivery of PHC services.

The Revitalization of the Community Health Care Initiatives in Bangladesh (RCHCIB), was introduced in 2009. Under this programme, over 13,000 CCs, acknowledged as 'the brainchild' of Prime Minister Sheikh Hasina, were established to extend PHC to "the doorsteps of rural people," enabling access for all to essential primary health services, and ensuring "no one is left behind" (MOHFW/WHO 2019).The CCs were also expected to coordinate with the field-level CHWs providing domiciliary services at that time. This is the key policy framework under which community-based health care programmes function in the country and are incorporated into mainstream health sector programmes, with its own Operational Plan (OP) and budget under the current Fourth Health, Nutrition and Population Sector Programme (HNPSP).

The GoB has formulated a number of policy documents related to the health workforce in the public sector in recent years. An Action Plan of Bangladesh Health Workforce Strategy was drafted in 2015, which reaffirms the GOB's commitment to the achievement of the SDGs. A supplementary document to the National Health Workforce Strategy, a National Strategy for Community Health Workers (MoHFW/WHO, 2019), was prepared in 2019. This strategy affirms Bangladesh's commitment to the PHC approach, as spelled out in Alma Ata and reiterated in the Astana Declaration, and the key role envisaged for CHWs in the delivery of PHC services.

Key stakeholders, their needs and roles

Countries in South Asia have large numbers of CHWs whose training, duties and retention schemes form a rich and confusing tapestry. Across South Asia, CHWs play a substantial role in PHC: through individual counselling; in community education and engagement; in the establishment of trust-based bridges between communities and health service planners and providers; and, in the facilitation of evidence generation and use at the micro-community level. Most are female CHW cadres developed to support promotion of desirable FP, maternal and child health, immunization, nutrition, sanitation and hygiene practices. Due to insufficient funding, village-based volunteers were replaced by volunteers or minimally-remunerated CHWs with assigned catchment areas covering multiple villages. Neither they nor the health centres they were affiliated with provide either the range of services or the quality of care that is acceptable for the PHC reforms underway. CHWs work with diversity of partners, Ministry of Health being a critical partner.

The beneficiaries of CHW's services, i.e. the rightholders, are socio-economically depressed communities who are disproportionately affected by a wider range of illnesses and their health needs remain largely unaddressed. The Astana Declaration therefore reiterated the need for promotive, preventative, curative, rehabilitative services and palliative care to be made accessible to all. Too many vulnerable individuals, families and communities fall into deep poverty due to health conditions that are largely either preventable or more likely to have better outcomes if diagnosed and treated early. The global health community therefore reaffirmed the need to accord higher priority to community-based health promotion and disease prevention, early diagnosis and care at the PHC level. They also decried the system-wide inefficiencies and the poor accountability of service providers that maintain the levels of out of pocket health expenditures highest among those who can least afford them, in exchange for what is strikingly fragmented, poor quality care.

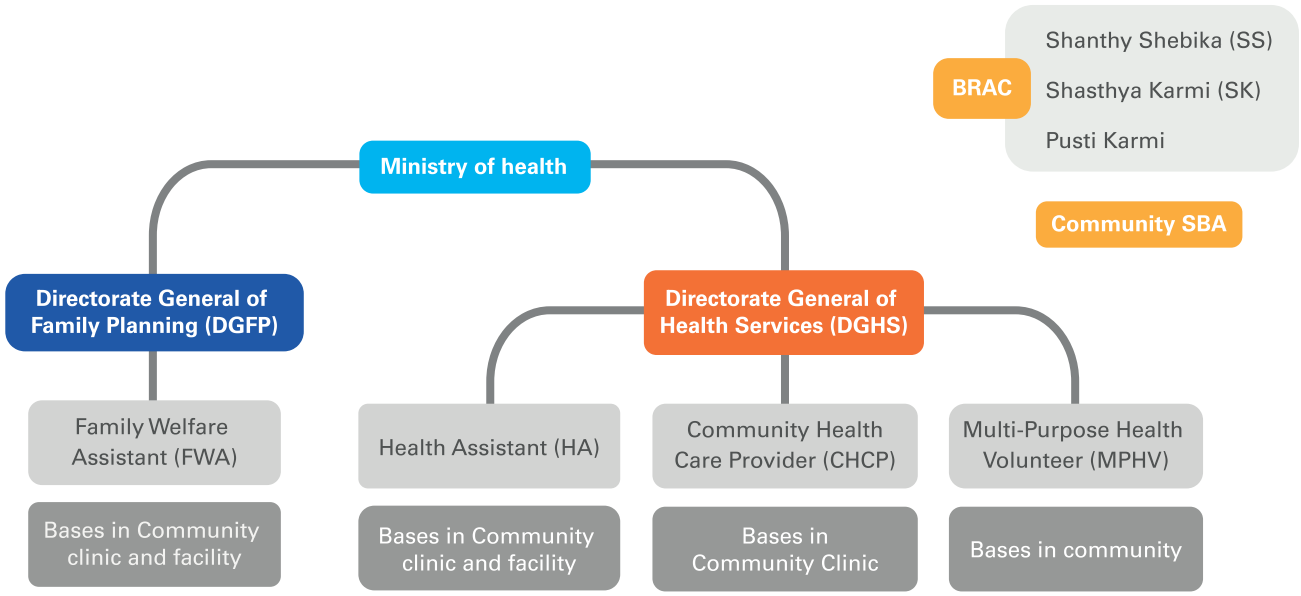
Severe shortages and markedly uneven distribution of health workers are a major impediment to the attainment of the ambitions stated in the Astana Declaration, especially at the PHC level and in areas where communities are socio-economically depressed.

The following comprises of the general list of stakeholders:

- Ministry of Health department and programmes at national and subnational levels
- Other government agencies – including local government, etc.
- Professional councils
- Training institutions
- Development partners
- Donors and multilateral agencies
- Formal/facility-based health workers
- Not for profit organizations and community groups
- Civil society/communities

As a key partner in the Community Health Road Map – a global collaboration to accelerate investment in community health – UNICEF works with governments and other development organizations to elevate community health in national agendas. UNICEF's approach integrates service delivery across sectors – including health; nutrition; early childhood development; social protection; education; and water, sanitation and hygiene.[5] UNICEF strengthens community health systems and provides promotive and preventative care to remote communities around the world. UNICEF also supports and trains community health workers to provide essential services, prevent the spread of diseases and respond to humanitarian crises.

Figure 2: CHWs and other key stakeholders in Bangladesh: relationships and links



[5] (source: https://www.unicef.org/health/community-health)

Purpose, objectives and scope of the evaluation

The overall objective of the evaluation is to understand the congruence between the current profiles, policy framework and system support for CHWs, especially those involved in RMNCAH programmes, and the profiles, policy framework and system support required to better serve RMNCAH, and to respond to PHC (PHC) reform and strengthening in eight South Asia countries, including Bangladesh.

The specific objectives of the evaluation are presented below:

- Evaluate current existing policy and system support in terms of the 15 areas of the WHO Guideline, including a gap analysis, to develop country-specific, prioritized recommendations for action. This should provide insight on how governments and partners can redesign and/or strengthen CHW programmes while ensuring that the quality of RMNCAH service delivery is protected and enhanced.
- Identify and prioritize ways in which the WHO recommendations can be translated from vision to action in a manner that creates functional integrated CHW teams within functioning support systems, in decentralized and non-decentralized national political and administrative systems that are aligned with the objectives, context and architecture of the national health system in each country.
- Consider how the process of strengthening CHW policies and system support can be made dynamic, responsive to context-specific evidence, linked to social accountability systems, and promote local, area specific, and national learning and innovation.
- Evaluate the extent to which the content of proposed national PHC and CHW related policy adjustments currently articulate effective transition management, to enable CHW cadres to be effectively reoriented into integrated and functional teams that are expected to cover expanding sets of community health services for the Post-Astana vision of community health systems strengthening for universal health coverage.

In addition, the evaluation included a comprehensive gender analysis that sought to determine the extent to which GESI considerations are incorporated into CHW programmes and policies. See specific details below and in the attached gender analysis report.

Intended Utilization and Users

The findings of this evaluation is expected to influence the community health systems strengthening plans of the relevant ministries and units in BangladeshEvaluation findings will be used for UNICEF's community health agenda and priorities and its partnership building and leveraging of technical and financial resources to strengthen national CHW programmes in Bangladesh to accelerate the strengthening of community health systems within ongoing or planned PHC reforms. The findings will inform national government plans and enhance UNICEF and partner's advocacy and technical guidance to local governments who, are instrumental in PHC priority setting, resource mobilization and allocation and the recruitment of the PHC workforce, including CHWs under national decentralization policies.

The evaluation will also be used to support the identification of priorities and sequencing of long- to medium-term health systems strengthening initiatives to ensure that system support functions, such as training, management, and supervision to enable CHW programmes function effectively. Such initiatives will also support their integration and support from health systems and communities to enable CHWs contribute within PHC teams, as well as be effective members of their communities, helping to address the social determinants including gender, that affect the health and well-being of the communities they serve. In addition to UNICEF, government of Bangladesh, other users will include implementing partners and other stakeholders who support programmes aided by CHWs.

Scope of the Evaluation

Subject of the evaluation

The evaluation focuses on the identified CHWs cadres in Bangladesh and the policies and system support that enable and guide their work. Recognizing the patriarchal systems under which CHWs are employed, this evaluation provides insights into overcoming gender barriers and bottlenecks to ensure highest levels of efficacy and effectiveness of CHWs and healthcare. The evaluation adopts the definition of a CHW used in the WHO guideline (WHO, 2018). Other health workers to whom CHWs relate are described for context where necessary, and to the extent that they form part of the support structure for CHWs, but they are not covered by this evaluation.

Geographical scope

The evaluation in Bangladesh assessed CHW policies and system support at national level only, with the evaluation team conducting interviews with key informants at this level to elicit their views and explore their perspectives on CHW policies, system support and on any planned or ongoing PHC reforms in the country.

Temporal scope

The evaluation is primarily focussed on existing policies or policies under design and therefore covers the period from early 2018 onwards, with reference to historical CHWs policies, where necessary.

Key Evaluation Questions

The evaluation responds to the following three key evaluation questions (KEQ), through the evaluation matrix (Table 1):

1. **KEQ 1:** What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?
   This is a descriptive KEQ. The key framework used to address this evaluation question was the WHO Guideline, as described below. All the data collected and analysed to address this question adopted a gender lens.

2. **KEQ 2:** What policy and system support improvements are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the-post-Astana or PHC reforms and strengthening.

This evaluation question entailed assessing actual or prospective country level commitments driven by the Astana Declaration and/or planned or ongoing PHC reforms, and the implications for existing CHWs policies and system support. A gender lens was also adopted in responding to theis KEQ to ensure gender-responsive efforts/strategies can be identified.

3. **KEQ 3**: What prioritized measures can be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?
This evaluation question entailed synthesising the key findings from KEQ 1 and KEQ2, and assessing what possible reforms, including gender-informed reforms are necessary and should be implemented, in order to enhance the contribution of CHW programmes to PHC, and to ensure gender equality, equity and responsiveness, given the individual country contexts.

The evaluation was informed by the indicative evaluation matrix below. The matrix was developed – pre-data collection. However, not all aspects achieved and/or addressed by the evaluation for various reasons. For example, although the original intention was to identify and analyse gaps in existing CHW policies and system support against PHC reform agenda, post-Astana commitments or PHC system strengthening plans, unfortunately there was little or no information available (from secondary or primary sources) on these areas. At the time of the evaluation, few countries had articulated or developed stand-alone post-Astana commitments or PHC plans that covered community health systems.

Table 2: Indicative Evaluation matrix

Evaluation questions	Primary Data Sources	Secondary Data Sources	Data Analysis & evidence generation	Outputs
KEQ 1: What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?	Key informant interviews with national level stakeholders including representatives from Ministry of Health, Ministry of Gender, Ministry of Women's Affairs, and other relevant line ministries; health policymakers, health planners and RMCAH programme managers; professional associations and regulatory bodies; international NGOs; international service providers (ISPs), local NGOs; development partners; and funders	These data will be extracted and analysed as part of a desk review, but also revisited and expanded once the desk review is completed and the second phase of the evaluation is being carried out to triangulate findings wherever possible. Sources include: • National policies • National plans and strategies • National reports • Peer reviewed literature • Donor reports • Evaluation reports • Training guidelines • CHW databases	Narrative synthesis of findings from key peer-reviewed and grey literature from across the eight countries produced from desk **review**. Synthesis structured around the 15 components of the WHO CHW guideline, gaps identified and options for improvement as well as further study in the second phase of the evaluation proposed. A framework (informed by the 15 components within the WHO Guideline; selected health systems strengthening/ building blocks (leadership and governance; service delivery; and financing); as well as factors related to gender and equity, engagement with the private sector; alliance-building; and resource mobilization) and on-going or planned post-Astana reforms or PHC strengthening plans was developed during inception phase to guide the data collected and **analysed from** the **key informant interviews** Throughout, key challenges and areas for adaptation and strengthening will be identified by participants. Data will then be synthesised by cadre, across cadres within a country, and across countries to generate top-level findings at the regional, national, and cadre levels. The analysis will involve transcript familiarisation, coding and synthesis of relationships between themes	Map of CHW cadres to be assessed in each country, validated and finalized with countries Map of policies related to community health worker programmes to be assessed for each country validated and finalized Map of available information for each country against the 15 core components in the WHO Guideline, key health systems building blocks and other factors including private sector involvement, alliance building, and resource mobilization created and validated Framework for analysis constructed informed by WHO Guideline, key health systems building blocks and other factors and identified gaps.
KEQ 2: What policy and system support improvements are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or PHC reforms and strengthening.				Map of post-Astana commitments for each country where available Map of ongoing and planned PHC reforms and PHC systems strengthening plans Gap analysis of existing CHWs policies and system support against PHC reform agenda, post-Astana commitments or PHC system strengthening plans.

Evaluation questions	Primary Data Sources	Secondary Data Sources	Data Analysis & evidence generation	Outputs
KEQ 3: What prioritized measures can be taken by government and partners to strengthen health policy and system support to optimize the contribution that each CHW cadre is able to make to PHC	Data sources as per KEQs 1 and 2		Synthesis of analysed data from KEQs 1 and 2	Recommendations and reform options to enhance the contribution of CHW programmes to PHC systems strengthening within the country context using relevant levers in the WHO and UNICEF[6] Operational Framework Set of feasibility and prioritization criteria to support countries in developing an action plan aimed to optimize the contribution that each CHW cadre is able to make to PHC. All recommendations and options adopt a gender lens and are gender-responsive

Methodology

The LSTM team used a mixed methods approach for this evaluation. This formative evaluation is intended to help with the on-going strengthening and evolution of the PHC components of national health systems. It is not an impact evaluation that seeks to measure the impact of CHWs, CHW programmes or the health system as a whole. This distinction has guided the selection of the methods to be used for this evaluation.

1. Data collection tools

Desk review

The LSTM team undertook a desk review of peer-reviewed literature and available national policies, plans and strategies, country reports, peer reviewed literature, United Nations, donor/development partner, INGO and local NGO reports, evaluation reports, training guidelines, and CHW databases. The review focused particularly on CHWs programmes and CHW cadres involved in RMNCAH service delivery. Data extracted and analysed as part of the desk review was revisited and expanded on during the implementation phase of the evaluation to triangulate findings wherever possible.

Specifically, the desk review mapped out and validated available CHW cadres in each country, their roles and responsibilities and system support across the 8 countries and any post-Astana or PHC strengthening plans. It reviewed international literature, and regional and national CHW policies, strategies and programmes against the WHO 15 policy options and recommendations, health system building blocks and highlighted gaps. A key aspect of the desk review was the analysis of the extent to which CHW programmes are gender-responsive. It also generated a list of key international and national references and resources that will be used to guide the overall evaluation process, which was circulated to all the country offices to enable them to identify any additional secondary data sources that the team should examine.

Key informant interviews (KIIs)

The desk review was complemented by qualitative data, collected through interviews with national level key informants (KIs) involved in CHW programmes in Bangladesh. LSTM worked with the UNICEF Country Office to draw up the list of KIs to be interviewed, which comprised national-level representatives from government, United Nations' agencies, development partners, and local and international NGOs. To save on resources and manage the time available for the study, key informants were sampled purposively to generate a diverse sample of participants, to ensure that data derived from KIIs were as rich as possible, and to ensure the inclusion of a gender-balanced range of organizations, cadres, and stakeholders.

Semi-structured topic guides (Annexes 1 and 2), informed by the evaluation framework (Table 1) and analysis plan (Table 2), were used by the LSTM evaluator to collect data to respond to the three KEQs, and to validate and triangulate the desk review findings, as well as collect any information not availed through the desk review. Using these guides the LSTM evaluator sought to elicit and explore key informants' views and perspectives on a range of topics including national CHW programmes, cadres and health system support; the policy environment; the role of gender in the design and implementation of CHW programmes, financing and resource mobilization, and the contribution of the private sector to CHW programmes. A gender-specific topic guide was used with key informants selected for their specialist knowledge of or work remit for gender and CHWs, to enable a more in-depth exploration

[6] PHC: transforming vision into action. OPERATIONAL FRAMEWORK. Draft for consultation A World Health Organization and the United Nations Children's Fund (UNICEF), 2018

of the gender issues and constraints that impact the effectiveness of CHW programmes, and the identification of efforts to address these constraints to improve the functioning of CHWs and strengthen PHC.

A member of the LSTM evaluation team conducted a total of 23 KIIs with 23 KIs, including three gender-focused KIIs in Bangladesh between 20 and 28 October 2019.

Participation of key stakeholders and duty bearers

Stakeholders and duty bearers participated in different capacities. UNICEF personnel participated in the selection of key informants. The LSTM evaluation team provided guidance for the UNICEF COs on a range of potential national level KIs for inclusion in the study, comprising policymakers and programme managers from the Ministry of Health, and other line ministries, including Ministry of Gender, Ministry of Women's Affairs and representatives from professional councils, associations and regulatory bodies, training and academic institutions, international and local NGO; United Nations' agencies, development partners and funders and the private sector. A list of KIs then drawn up, validated and finalized. Selected persons participated in the KIIs.

Three members of the LSTM evaluation team also participated in the UNICEF Regional Management Team (RMT) meeting in Nepal in April 2019. They presented an overview of the evaluation and preliminary findings from the desk review, facilitated a question and answer session, and elicited feedback and inputs from participants on the study. During the UNICEF RMT, the LSTM evaluation team also conducted Key Informant Interviews (KIIs) with UNICEF Country Office representatives. Another level of participation was the review and validation of country reports. Both UNICEF and the relevant government stakeholders provided feedback on the reports before being finalized.

2. Data analysis

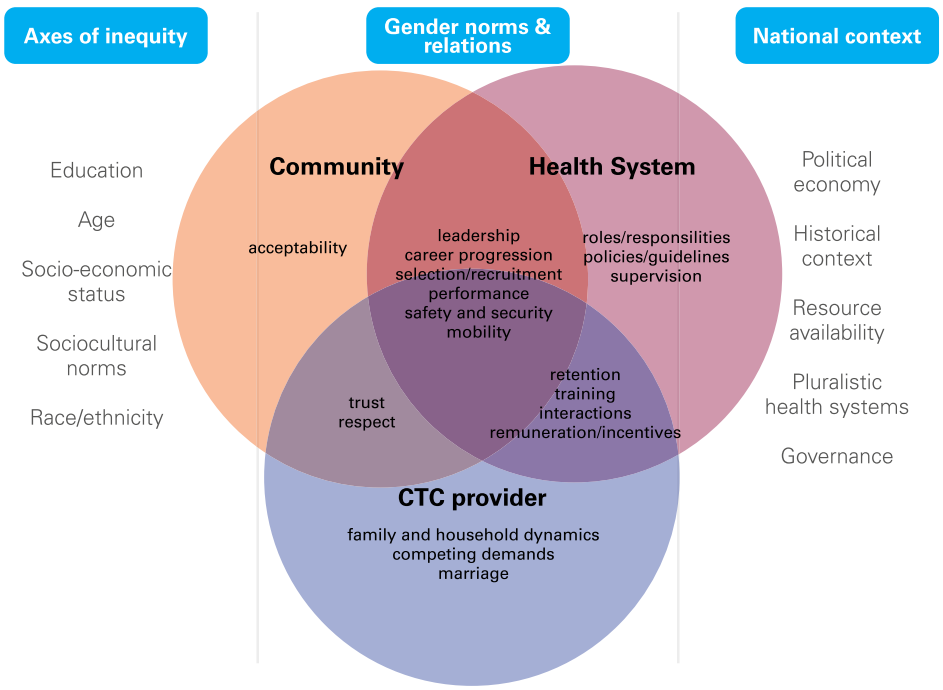
KIIs were digitally recorded with the participants' consent. All interviews were conducted in English and were transcribed verbatim soon after collection, anonymised and all identifying information removed. The transcribed KIIs material was cleaned and then underwent a framework analysis by the LSTM team using NVivo Version 11. A data analysis plan, based on the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018), the health system building blocks (WHO, 2007), PHC levers (WHO/UNICEF, 2018), the WHO gender-responsive Assessment Scale (WHO, 2011), and the Steege et al (2018) conceptual framework. Other areas, such as PHC reforms and the contribution of the private sector sector, were also included in the analysis to help address and respond to the evaluation questions.

Table 3: Analysis Plan

Topic	HS Building Block	PHC Levers	Gender Analysis	Research questions
CHW programmes and cadres	Health Workforce	PHC workforce	Gender considerations for CHW policy and programmes; affirmative action to preferentially select women to empower them and, where culturally relevant, to ensure acceptability of services by the population or target group	KEQ 1
CHW roles and responsibilities	Health Workforce; Service delivery	PHC workforce; Service delivery	Gender norms and constraints in delivering particular services; household roles/ responsibilities	KEQ 1
Selection, education, certification	Health Workforce	PHC workforce	Requirements for selection for training/ education; recognition and certification of knowledge and skills	KEQ 1 & 2
Management and supervision, including remuneration, contracting and career ladders	Information; Health Workforce	PHC workforce; monitoring and evaluation	Supportive supervision; empowerment; leadership roles; remuneration; career progression	KEQ 1 & 2
Integration with health system and communities, including target pop size, data collection and use, types of CHWs, community engagement, and availability of supplies	Health Workforce; Medical Products	Engagement of community; Appropriate medicines and products	Acceptability by community; workplace health and safety	KEQ 1 & 2
RMNCAH focus	Service delivery	PHC workforce	Gender norms and constraints in delivering some RMNCAH services	KEQ 2

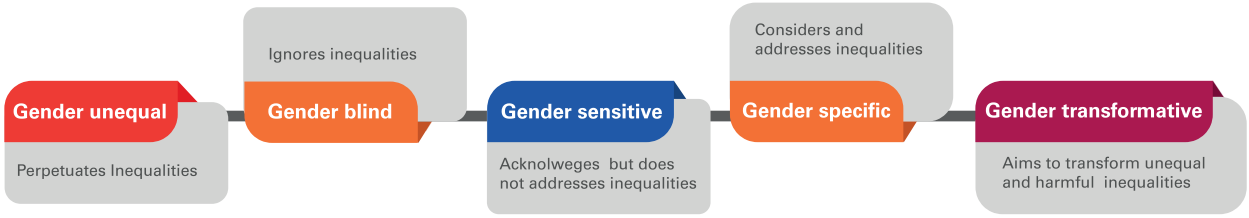
Topic	HS Building Block	PHC Levers	Gender Analysis	Research questions
Leadership and Governance	Leadership and governance	Political commitment and leadership; Governance and policy frameworks	Leadership opportunities; women's representation in leadership positions	KEQ 1, 2 & 3
PHC reforms	Service delivery; Health Workforce	PHC workforce; Adequate funding and equitable allocation of resource; Political commitment and leadership; Governance and policy frameworks	CHW workforce recognized as a key component of the PHC workforce;	KEQ 2
Financing and Resource mobilization	Financing; Medical products; Service delivery	Adequate funding and equitable allocation of resource	Renumeration; training; supplies and equipment	KEQ 2 & 3
Private sector	Service delivery; Health Workforce; Medical Products	Engagement with private sector providers		KEQ 2 & 3

Figure 3: Conceptual Framework for gender analysis



Source: Steege et al., 2018

Figure 4: Gender-responsive Assessment Scale



Additional documents were identified by KIs during the conduct of the KIIs in Bangladesh, and these were reviewed by the LSTM team. Key among these was the 2019 National Strategy for Community Health Workers (MoHFW, 2019) and the 2019 Independent evaluation of community-based health services in Bangladesh (MoHFW/WHO, 2019).

Gender Analysis Frameworks

The gender analysis draws on the Steege et al. (2018) conceptual framework (Figure 1), which focuses on gender relations and factors affecting the working lives of community health service providers at the individual level (family and household dynamics, decision-making competing demands), the community level (social and cultural norms, acceptability, trust respect) and the health system level (gender policies and gendered system support, roles and responsibilities, and integration). At the individual level, family influence and household dynamics are important factors affecting CHWs; at the community level, safety and the ability to move around are aspects considered; while at the health systems level, gender relations and norms affecting training and supportive supervision, remuneration and career progression are important factors considered. (Steege et al., 2018).

The analysis also draws on the WHO gender-responsive Assessment Scale (WHO, 2011) (Figure 2) to determine the extent to which GESI considerations are incorporated into CHW programmes and policies.

The scale includes five stages of GESI responsiveness within policy and programmeming as follows:

- **Gender-unequal:** perpetuates gender and other forms of inequality by reinforcing unbalanced norms, roles and relations.
- **Gender-blind:** Ignores gender and other forms of inequality.
- **Gender-sensitive:** considers gender and other forms of inequality but takes no remedial action to address it.
- **Gender-specific:** considers gender and other forms of inequality and takes remedial action to address it but does not change underlying power relations.
- **Gender-transformative:** addresses the causes of gender-based and other forms of inequality by transforming harmful norms, roles and relations through the inclusion of strategies to foster progressive changes in power relationships.

3. Frameworks used to inform data collection and analysis

The evaluation uses the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018) and the policy and system enablers it identifies, and in particular, the fifteen (15) policy recommendations it presents, as a benchmarking framework to map and assess CHWs policies and system support, and identify gaps and areas for optimising CHW programmes in the eight study countries, including Bhutan.

The Guideline's 15 policy recommendations are organized around three broad areas as follows:

1. Selection, education and certification (selection, duration of pre-service training, competencies in pre-service training curriculum, pre-service training modalities and competency-based certification)
2. Management and supervision (supportive supervision, remuneration, contracting agreements, and career ladder)
3. Integration into and support by health systems and communities (target population size, collection and use of data, types of CHWs, community engagement, mobilization of community resources, and availability of supplies).

For the purposes of the evaluation, health system support is defined as the support that the health system needs to provide to optimize CHW programmes, including the education, training, management, supervision, remuneration and compensation of CHWs, the provision of commodities and supplies, clear definition of roles and responsibilities, and expectations, as well as adequate financing and the integration of such programmes into the health system and the community.

The evaluation framework is also informed by the WHO six health system building blocks (WHO, 2007), namely, leadership and governance; service delivery; health system financing; the health workforce; medical products, vaccines, and technologies; and health information systems. In addition, the governance, policy, and finance and operational levers presented in the WHO and UNICEF Operational Framework (WHO/UNICEF 2018) provides useful benchmarks levers for assessing progress on PHC strengthening.

The LSTM team adopted a gender lens in the review of secondary data, the design of the data collection tools, and the analysis of the data. A gender-specific topic guide was

designed to target key informants with specialist knowledge of, or responsibility for gender and CHWs, to enable a more in-depth exploration of the gender issues and constraints that impact the effectiveness of CHW programmes, and the identification of efforts to address these constraints to improve the functioning of CHW programmes and cadres and strengthen PHC. The gender component of the evaluation drew on the Steege et al (2018) conceptual framework of gender norms and relations across the levels of the individual provider, the community and the health system.

The team also assessed CHW programmes and policies using the WHO gender-responsive Assessment Scale (WHO, 2011) that presents findings along the five levels of the scale including, 1) gender-unequal, 2) gender-blind, 3) gender-sensitive, 4) gender-specific, and 5) gender-transformative.

Citations (and in some cases, links) to the frameworks are included in the reference section in Annex 3 for further review.

Application of a rights-based approach, and Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and Gender Equality and the Empowerment of Women.

As reflected in the frameworks applied, this evaluation uses a gender-responsive evaluation methodology, and data analysis techniques. Because women comprise a substantial number of CHWs in many SA countries, the evaluation also looks at aspects of inequality, examining how existing policies and systems may unequally affect women in the selection, training and promotion in the different CHW cadres.

At the core of this evaluation is an assessment of Gender Equality and the Empowerment of Women (GEEW). Both the WHO gender-responsive Assessment Scale and the framework proposed by Steege et al, which are used in this evaluation, focus on gender equality and empowerment. The ability of existing systems to reach all persons including those who are marginalized is also explored

4. Ethical standards

The proposal for the evaluation was submitted to the Institutional Ethics Review Committee of LSTM and full ethical clearance for the study was granted by LSTM (Annex 4). LSTM has ensured, in line with its internal policies and code of conduct, that the research associated with the evaluation follows the ethical principles and considerations outlined in the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation and UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (CF/PD/DRP/2015-001. In addition, the UNEG norms and standards were observed.

Written informed consent was obtained from all key informants (KIs) in this evaluation using the LSTM Research Ethics Committee (REC) consent template, adapted for this evaluation. The template consists of an information sheet and certificate of consent. LSTM's stringent procedures for obtaining consent adhered to the Helsinki declaration on the rights of subjects. These rights included autonomy (ability to participate or withdraw from the study at their own free will), beneficence (that the benefits of participation to the respondent outweigh the possible harms) and justice. Written consent included the participants' consent to participate in the interview and for the interview to be digitally recorded to aid in the transcription.

The participant information sheet, which explained the purpose of the study and all the possible benefits and harms, was provided to respondents in advance of the interviews and also reviewed with the participant, if required, before the start of the interview. The participant was provided with the opportunity to ask questions and responses were provided to the queries and issues raised. Participation was on a voluntary basis and all participants were assured that they had the right to withdraw from the interview at any stage without needing to offer any explanation. Participants were also encouraged not to disclose any information they are not comfortable with sharing and to decline responding to any statement they considered sensitive. Every effort was made to ensure that the confidentiality and privacy of participants was protected at all stages of data collection and processing. Confidentiality and anonymity were ensured and assured to the participants explicitly in writing and verbally at all stages of the study to ensure that no data or responses/statements could not be traced to the participant.

All members of the LSTM evaluation team involved in conducting the KIIs received training in good interviewing skills and principles of data confidentiality. Participants were informed about the study in advance (written communication and telephone calls for key informants) and prior to data collection to ensure that participants understand the purpose of the study and their rights to participate (voluntarily) or not and to withdraw from the study at any time without prejudice.

All interviews were conducted in English and were transcribed verbatim soon after collection, anonymized and all identifying information removed. The transcribed KII material was cleaned and then underwent a framework analysis by the LSTM team using NVivo Version 11. Recordings of interviews were stored on password-protected data devices.

5. Limitations and mitigation measures taken by evaluation team

- Availability and quality of secondary data related to VHWs
  - **Mitigation measure:** To ensure maximum responsiveness of stakeholders and access to relevant and quality data, the LSTM evaluation team sought the support and guidance from UNICEF country offices in approaching and following up with relevant partners to obtain the necessary information. Processes for the quality assurance of secondary data put in place for the desk review were applied and where possible, triangulation of data collected through KII was used to validate findings.
- Limitations of the qualitative research methods used such as participant and interviewer bias during the key informant interviews (KII)
  - **Mitigation:** The LSTM evaluation team used topic guides with open-ended questions to minimize interviewer/facilitator bias and probe with follow-up questions to clarify intent and

Table 4: Selected characteristics of CHWs employed by Government of Bangladesh

Type of CHW	Number	Sex	Employment Status
Family Welfare Assistant (FWA)	19,583 (2019)	Traditionally Women	Formal government salaried cadre
HA (HA)	15,213 (2019)	Women and Men	Formal government salaried cadre
Community Health-Care Provider (CHCP)	12,293 (2019)	Women and Men	Project funded through CBHC Programme Trust
Multipurpose Health Volunteer (MPHV)		Prioritizes women (2:1 woman: men ratio)	Mostly student volunteers, on MoH annual contracts; receive monthly performance-based incentives

Table 5 : Selected characteristics of CHWs employed by BRAC

Bangladesh NGO BRAC	BRAC (NGO) Shasthya Shebika (SS)	91,000 (2011)	Women	BRAC supported unpaid part time volunteer; receive performance-based incentives
	BRAC Shasthya Kormi (SK)		Women	BRAC employed paid part time CHW
	BRAC Pusti Karmi (PK)		Women	BRAC employed paid part time CHW

meaning. Independent coding of qualitative data was performed by the LSTM team to minimize the risks of bias.

- Limited generalizability of the evaluation findings due to the limited availability of stakeholders for interviews during the field visit.
  - **Mitigation:** By using qualitative research methods, such as KIIs, the evaluation team sought to obtain in-depth information to answer evaluation questions. Generalisability was not the main goal of qualitative research. The LSTM evaluation team used purposive sampling carefully targeting information-rich participants to represent (not statistically) the broad types of informants relevant to our evaluation.

Findings

1. Current CHW profiles, roles and responsibilities, policies and system support

This section responds to KEQ 1 and provides an overview of the current profiles, roles and responsibilities of the identified CHW cadres in Bangladesh that are involved in the provision of RMNCAH. It also reviews and assesses the policies and support these cadres receive from the health system.

1.1. CHW profile in Bangladesh

KIs interviewed for the study shared that Bangladesh has a long history of CHW programmes effectively contributing to the attainment of public health goals. Historically, CHW programmes were operating in the country before independence, and CHWs are credited with playing a key role in the success of the Control of Diarrhoeal Diseases programme, the FP Programme and the Expanded Programme on Immunization.

The key government CHW cadres in the country are as follows:

- HA (HA) under the DGHS
- Family Welfare Assistant (FWA) under DGFP
- Community Health Care Provider (CHCP) under the DGHS
- Multi-Purpose Health Volunteer (MPHV) under the DGHS

CHCPs are full-time in the CC, while the FWA and HA divide their time between the clinic and the community, providing services three days a week in the clinic, and three days in the community, moving door-to-door. Over the last few years, the GoB has introduced another cadre, the MPHV, on a pilot basis in 19 subdistricts.

In addition to the cadres above, some KIs identified the Family Welfare Visitor (FWV) under the DGFP as a CHW, as this cadre is mandated to conduct outreach in the community. The National Strategy for CHWs also refers to the 3,500 paid peer volunteers or auxiliary CHWs recruited by the DGFP, to cover the shortage of FWAs. These have been trained to provide delivery, nutrition and FP services as well as ***'promoting delaying marriage for adolescent health care'*** and are remunerated.

Table 6: CHW posts sanctioned versus filled

Cadre	Sanctioned posts	Filled posts	Vacancy rate (%)
Family Welfare Assistant (FWA)	23,500	19,583	17%
Health Assistant (HA)	21,000	15,213	27%
Community Health Care provider (CHCP)	15,213	12,293	19%

Source: National Strategy for CHWs, 2019

While the above cadres are the key CHWs within the government sector, there are others active in the country who are either recruited by NGOs or other agencies. The largest programme amongst these is that managed by BRAC, a local Bangladesh NGO, whose CHWs include the following:

- Shasthya Shebika (SS)
- Shasthya Kormi (SK)
- Pusti Karmi (PK)

The Community Skilled Birth Attendant (CSBA) is another cadre produced and providing community-based MNCH services. These are mostly FWAs, female HAs and CHCPs who have also received Skilled Birth Attendant (SBA) training. This cadre is few in number, and mostly work for NGOs or private agencies. For example, between 2012 and 2018, CARE Bangladesh, together with GlaxoSmithKline (GSK) and other key stakeholders, trained and produced 319 private CSBAs, with the aim of reaching underserved populations with services. They received six-months Skilled Birth Attendant (SBA) training , accredited by WHO and MoHFW, followed by three months of on-the-job training. Over the project period, this cadre were providing maternal and child health services, primary treatment of non-communicable diseases (NCDs) like diabetes and hypertension in underserved/remote and poor communities in Sunamganj district (Hossain et al, 2020).

According to the National Strategy for CHWs, there are close to 185,000 CHWs in the country currently, with 70,000 of these employed by the government. This translates to 3.8 CHWs per 10,000 population. Government-sanctioned and filled CHW posts under the DGHS are shown below.

The 2019 MOHFW/WHO Evaluation of Community-based Health Services found that that almost all CCs had a CHCP in post (10 per cent vacancy rate), however vacancy rates among the HA and FWA cadres was higher, varying between 9 per cent and 50 per cent (MoHFW/WHO, 2019).

In 2011, there were approximately 91,000 of the BRAC SS cadre active across the country.

1.2. Key policies and policy environment

While CHWs have been in existence since before the 1970s in the country, Bangladesh introduced the CBHC programme in 1998. After a break of a few years, due to political reasons and a change in government, the Revitalization of the Community Health Care Initiatives in Bangladesh (RCHCIB), was introduced in 2009. Under this programme, over 13,000 CCs, acknowledged as 'the brainchild' of Prime Minister Sheikh Hasina, were established to extend PHC to "the doorsteps of rural people," enabling access for all to essential primary health services, and ensuring "no one is left behind" (MOHFW/WHO 2019).The CCs were also expected to coordinate with the field-level CHWs providing domiciliary services at that time. This is the key policy framework under which community-based health care programmes function in the country and are incorporated into mainstream health sector programmes, with its own operational plan and budget under the current Fourth Health, Nutrition and Population Sector Programme (HNPSP).

The GoB has formulated a number of policy documents related to the health workforce in the public sector in recent years. An Action Plan of Bangladesh Health Workforce Strategy was drafted in 2015, which reaffirms the GOB's commitment to the achievement of the SDGs:

"The Government of Bangladesh (GOB) is obligated to ensure that all citizens enjoy a quality of life assured with basic healthcare and adequate nutrition as stated in the Article 15a of the Constitution. Vision 2021 of the Government aims to transform the country Bangladesh from a developing country into a middle-income country by 2021. The Government is also committed to achieving the globally accepted goals such as SDG to be achieved by 2030" (MoHFW/WHO, 2017).

One KI, a development partner, also spoke about how the government has a constitutional obligation to provide free health care to all people, and that this strategy is to support the government to achieve this goal.

A supplementary document to the National Health Workforce Strategy, a National Strategy for Community Health Workers (MoHFW/WHO, 2019), was prepared in 2019. This strategy affirms Bangladesh's commitment to the PHC approach, as spelled out in Alma Ata and reiterated in the Astana Declaration, and the key role envisaged for CHWs in the delivery of PHC services. The strategy is based on the WHO Guideline on CHWs and plans their roles under the three domains, namely, selection, education and certification; management, supervision and integration; and support by health system and communities (WHO, 2018).

"We wanted that strategy because human resource for health strategy, they (CHWs) were not mentioned, but they are a major workforce for health. So, we wanted... is not a separate strategy, it is for the human resource for health strategy. And it is an annex to that strategy and our... the addition, in addition to that amendment or that kind of thing. And we wanted that how this community health workforce be more effective and efficient, how government can use them more efficiently. That was our main agenda in that community health workforce strategy". (Development Partner)

Several national-level KIs referred to the National Strategy for CHWs as a key policy document that envisions the role of CHWs for the future and pointed out that it harmonizes the roles and responsibilities of the different CHW cadres, and government and NGO CHW programmes. However, some stakeholders cautioned that while the policy document set out a strategic vision, actual implementation plans has not been worked out yet, and translating the vision into action may present challenges. The same level of leadership and commitment that supported the development of the strategy is now needed to get it to the implementation stage.

"Well, it requires a strong implementation plan. Usually that's how strategies work. You get a broader strategic direction. And then how the execution requires more detailed planning, because the execution is done by multiple departments. You know, that's a common problem with all the initiatives in Bangladesh". (Development Partner)

"Sometimes the ministry leadership is also important, if the Secretary is interested, he can push. From any point there should be a pressure. Otherwise it sometimes takes like... Like the human resource action plan, I don't know whether... Sometimes the action plan is developed and then it's not implemented. So, even the action plan is developed, it is not implemented. So, that... we need to be, there should be, so you need to have some stakeholders or some pressure point to move it forward". (Development Partner)

1.3. Leadership and governance

The CBHC and CHW programmes fall under the Ministry of Health, under the two Directorates – Health Services and FP. The CBHC programme, especially the CC component, is seen to have political commitment at the highest level. As CCs are a priority programme of the Prime Minister, they have received a lot of attention and support.

All the political bodies, I mean the union chairman, or the Upazila chairman, or the UNO, or the UH&FPO, all support them because this is a Prime Minister headed programme. So, once it is a Prime Minister headed programme, then everybody supports the community clinic and the CHCP. (Development Partner)

The 2019 independent evaluation of community-based health services concluded that while the CBHC approach remains very relevant, its effectiveness has been constrained by a number of factors (MoHFW/WHO, 2019). Where relevant, findings from the KIIs are complemented by those of this evaluation.

With government leadership, CHW programmes are provided through two Directorates in the Ministry. Several informants expressed concerns about how this is affecting coordination on the ground between health officials and providers, as they are now operating in vertical silos. They reported that despite wide divisions at the policy level coordination at the lower service delivery levels and frontline tends to be better, but this often depends on personalities and local leadership. They felt unification of the directorates would be a key step forward in harmonizing CHWs' roles on the ground.

There is a gap in the policy level but if you go into the community level, with HA and FWA there is no gap. They want to work together but the problem is there. The ministry at their level, they do not want to unify. If they unify then some of the people will lose their positions. (NGO representative)

And suddenly the decision came, the ministry is bifurcated with two different secretaries. So, health services is in a separate division, whereas you have implementation structures, parallel structures. If you look at district, both health and FP has service providers, facilities in both domains. So that correlation is only ... the issues are only widening, the gaps are only widening at the national level. But if you go down to the district, you'll see better coordination because you know, if the managers get along well, at the district level, usually it gets conveyed to the Upazila level. At the frontline level, it is much easier to ensure that coordination. (Development Partner)

Some KIs talked of how policies are often not evidence-based. One gave the example of the creation of the MPHV cadre, who are often influenced by individual and political interests. They felt such politically-charged decisions, while well-intentioned, may not be strategic or in the best interest of the sector or country.

Actually, this is this (Multi Purpose Volunteer) is a top-down one. It is not that, it is, after a lot of consultation it was done. You know, in our country, everything is, how I will put it is that, suddenly an issue came, and some good people, interested people thought that, it was a good way, so they pursue, to do it. The same way, the multipurpose volunteers concept came. So, always there is a political influence, I say politically not in the sense of national politics, "p" not that "P," always there will be a liking or disliking. So that will remain a big constant for that. (NGO representative)

1.4. CHW roles and responsibilities and focus on RMNCAH

All respondents felt that historically and to the present day, the focus of CHWs' roles and responsibilities has been on different aspects of RMNCAH service provision. The CCx, including the three cadres posted there – the CHCP, HA and FWA – are responsible for the provision of maternal and neonatal health care services, including deliveries, ANC and PNC, immunization; integrated management of childhood illness, reproductive health and FP services and counselling, and health education. They are also responsible for screening for NCDs and referrals to higher-level facilities. HAs and FWA complement these CC-based services through the provision of domiciliary and community-based. In the past, the FWA and the HA exclusively provided domiciliary services. However, they are now expected to spend three days a week at the CC, with the remaining three days spent providing services at community and household levels. Each CC, with one CHCP is expected to cover a population of 6,000. Similarly, there is supposed to be one FWA and one HA in each ward, with nine such units in each union.

FWAs are primarily responsible for the provision of FP services, including counselling couples on FP, providing FP commodities, and referring clients for FP services to the CC, or Union Health and Family Welfare Centres (UHFWC). In addition, they are responsible for identifying and registering eligible couples and pregnant women, referring women for antenatal care and deliveries. Some FWAs were upskilled to become community SBAs, but as they do not have the required skills to manage obstetric emergencies, this cadre has been phased out, and the focus is now on training diploma midwives. The HAs are mainly responsible for the promotion of immunization services, as well as the provision of MCH services, community IMCI, adolescent health, social awareness creation, couple and pregnancy registration, death notification and referrals.

The CHCP, based in the CC six days a week, provides preventative, promotive, health education services and curative care for minor illnesses. They provide antenatal care, post-natal care, and contraception, though some respondents expressed concerns about the quality of such care. Some Community Clinics conduct deliveries, though there were diverse opinions amongst the respondents on whether this was indeed a positive development. Deliveries are also being conducted in UHFWCs by SACMOs or FWVs posted there. But the overall direction of the national policy was towards the production and deployment of a professional midwifery cadre to provide midwifery services in the long term.

CHCPs also offer screening for NCDs such as hypertension and diabetes and refer clients to higher level facilities for further treatment. All respondents indicated that NCDs are emerging as a major problem in the country and therefore will be a key area of focus for CHWs in the future. However, they were unanimous in the view that that RMNCAH would continue to be the major focus area of CHWs, more so since the country was lagging behind in achieving key RMNCAH indicators.

"So, coming with the NCD and other non-communicable disease burden, this is a new paradigm shift. But CCs also have been equipped to deal with these things. Now the CCs, they have diagnostic devices for diabetics, diabetes mellitus, they have this measuring blood pressure, all these things are there. So, people are side by side dealing all this thing, but they're not forgetting maternal neonatal services." (Development Partner)

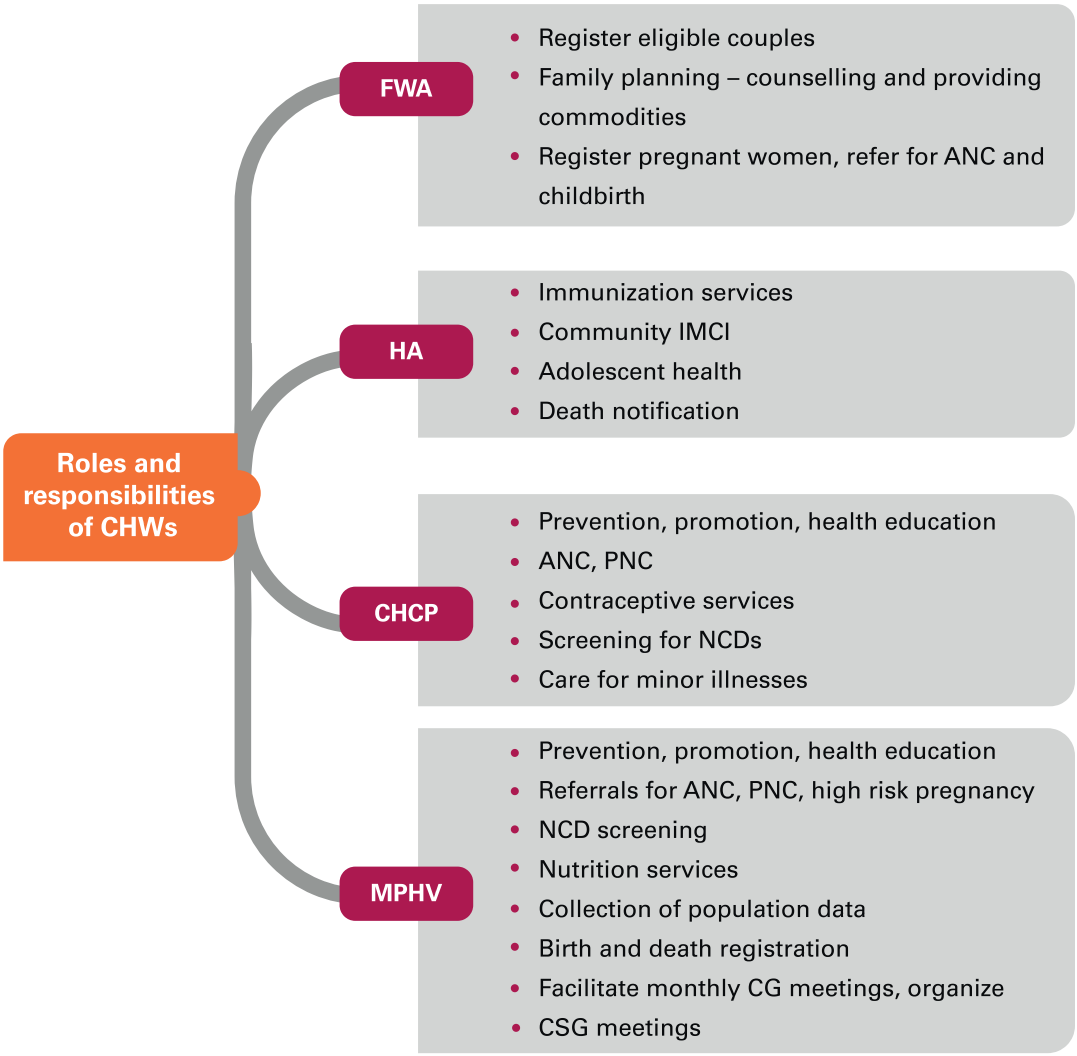
While BRAC's CHWs focus largely on RMCAH services, NCDs are also a key focus area. SS are mainly involved in FP, pregnancy identification, and antenatal check-up, assistance on delivery, postnatal check-up, neonatal care and care of under five children. The SK is responsible for identifying pregnant woman, ANC, screening for pregnancy complications, counseling for facility delivery, offering immediate and essential neonatal care, treating ten common illnesses, identifying TB patients and providing DOTS for them, recording data for monthly and annual report preparation. While the SS counsels women and mothers, the SKs actually provide the ANC, PNC and childcare services to the women and mothers. The SK receives supervisory skills development and supervises the SS.

Shasthya Shebikas also support TB directly observed treatment, short course (DOTS) in the community for those needing tuberculosis treatment. The Pusti Karmis are responsible for providing nutritional advice to families with children aged under five years, and to pregnant women. There are no corresponding nutrition workers in the government sector – an earlier cadre of Community Nutrition Promoter was reportedly phased out.

Informants felt that there is a disproportionate focus on curative care in the CCs to the detriment of preventative and promotive care. This is substantiated by the findings of the CBHC Evaluation, where curative services represented 86 per cent of services provided by CCs, and there was low demand for promotive and preventative services.

For the people at the rural level, they are more fascinated to get the medicines. So, ultimately what happened? This CHCP who has been trained for 12 weeks, very plain preliminary training, so, once they have given the medicine, all this authority, then there is a shift of services that primary... that ultimately focuses on curative services for small ailments- fever, diarrheal disease, all this thing. So preventative and promotive services are hampered. (Development Partner)

Figure 5: Roles and responsibilities of government CHWs in Bangladesh



The MPHV cadre, working primarily at the community and domiciliary levels, is expected to undertake promotion, prevention, health education and data gathering activities, including referrals of high risk pregnancies, referrals for ANC, PNC, and NCD screening, disease control, provision of nutrition services, as well as the collection of population data and birth and death registration. They also support the CHCPs to facilitate monthly CG meetings and are responsible for organizing CSG meetings. Each CC is expected to have five MPHVs, with each MPHV assigned to 250–300 households. Informants recognized several challenges affecting the ability of these CHWs to effectively carry out their roles and responsibilities. Some respondents reported that FWA and HAs are overburdened – over the course of time, additional responsibilities have continuously been added to their scope of work. The 2019 Evaluation of CBHS also highlights the expanding roles and responsibilities of these cadres and the impact this is having on community and domiciliary activities.

The FWA cadre used to be one of the most effective cadre, especially, when the FP programme was at its peak. And FWAs in Bangladesh were well known for that huge contribution to the FP programme. But that needs to be analysed, how that gradually became a weak link in the same system. So, you know, what is that they were originally conceived as FP workers, then gradually additional responsibilities got added. And similarly, as HAs, they were already EPI workers, and then we kept on adding more responsibilities. (Development Partner)

Because the number is less, the population is really high. They can only visit eight families. This is... if anyone can work hardly, with whole of the heart, in two months they can cover one family. One round. (MoHFW senior official)

Some respondents, however, felt that while on paper, it seems that FWAs and HAs are overburdened, in practice, this is not always the case, as they frequently do not perform all the tasks assigned to them and are often not found in the CC or the community. They attributed this to the absence of robust monitoring and accountability mechanisms.

The extent to which community and household-based health services are a key government priority is a concern raised both by respondent and the 2019 Evaluation; whether there will be investment and commitment to CBHS will be sustained as knowledge of FP and uptake of immunization and other services improves, and with more sophisticated means of communication. The CBHS OP also indicates that these were factors behind the MoHFW's decision to review the continued relevance of 'blanket domiciliary services' by HAs and FWAs, and to post these cadres to the CC to improve staffing levels in these facilities (MoHFW, 2017).

According to one respondent, the MPHV has been introduced to address the gap in community-based health services; to improve demand and increase access to and utilization of health services at the grassroots level.

Now the total focus is EPI, they do the EPI very perfectly. That's because there is a huge demand, demand has been created but have the promotional activity. They have still a routine of visiting the CCs for 2 or 3 days, to the EPIs some days. Another day they are supposed to visit domiciliary visit. But this task they are less attentive now a days, now they do one thing very carefully that is the EPI. Even in CC they are supposed to go three days, but they mostly go one day and many places they don't go. (NGO representative)

One issue is discussed at length here is, the CC versus the outreach work. So, the HAs and family welfare assistants are also seen as part of the CC and they are supposed to spend three days in the clinic, which is a big change from their original function, which was... they were supposed to be full-time in the community providing... like if you look at FWA she was supposed to cover 800 eligible couples in that area. Now the time is reduced to half; half the time she is supposed to be sitting in the CC. And oftentimes that becomes also a good excuse for not going to the community. So, you 'on't find them at the CC. You 'on't find them in the community. (Development Partner)

Because of the staffing shortages and the fact that coverage areas have not been redefined to match population growth, respondents reported that the CC and these CHWs often cover a larger population than they are mandated to, and FWAs and HAs can be assigned to more than one CC. This affects the provision and quality of both facility- and community-based PHC services.

When the programme was taking place, it was thought that all the CC will be for approximately 6,000 population, but this population is of 1990. But in the meantime, population has increased quite substantially, so now, if we observe that, now the CC in area from 6,000-8,000 population reside. (MoHFW consultant)

In addition to these challenges, respondents noted the structural issues affecting the integration and reach of the services provided by these CHWs. As noted above, and in the 2019 Evaluation of CBHS, the inadequate coordination between these CHW cadres, results in missed opportunities to increase coverage with promotive, preventative and curative services, and to reduce duplication and inefficiencies. The effective utilisation of the newly introduced MPHV is also at risk unless coordination is improved amongst the various cadres working at the CC.

But then again, there are some of the structural issues, if you look at the area, location for the HA and the family welfare assistant. They are not harmonized, so FWAs location is based on the number of eligible couples that she has to cover. Well, whereas HAs' area is divided based on the units for EPI. They have overlaps. So, it's not that they are mutually exclusive. So, when even when we look at, you know, how do we ensure registration of pregnant women, the areas are not properly demarcated. Even with the CC... So, it's like, if you look at a population of CC, so if you look at a catchment area of a CC, which is supposed to be 6000. So, you will find usually maybe FWA, which covers this area. But she has area outside this CC. And so, this is an FWA area. And there may be a HA which has an area something like this, and another HA, which has an area like this. So, the 6000 doesn't really add up, if you bring the HA from this area, and FWA from this area, it still doesn't add up to the same geography. So those are challenges. (Development Partner)

The lack of coordination between government CHW programmes and those run by the NGOs was also highlighted by some informants. NGO and government programmes were perceived to be running parallel to each other.

1.5. Selection, education and certification

The FWA and HA are selected through formal government recruitment processes. Criteria for selection include educational qualifications – both FWAs and HAs need to have passed eighth grade. Similarly, CHCPs are recruited through a general recruitment process and need to have undergone 12 years of schooling and passed the higher secondary school examination. There also seems to be gender criteria applied – FWAs are traditionally female, while Has are male. Both male and females are recruited as CHCPs. While candidates from the local community seemed to be preferred, according to some key respondents there is no community engagement in the process of selection of any of these CHWs. While recruitment prejudices were uncovered in the study, there were also positive challenges to social norms by BRAC, experiences that can be considered and advocated by development partners (see gender analysis, below).

The MPHV on the other hand is expected to be from the local community; preferably selected from within the Community Group (CG) and the Community Support Group (CSG), established to monitor and support the CCs. However, even with this cadre, there did not seem to be any community engagement in their selection.

While educational qualifications are specified as above, several key respondents reported that CHWs are often much better educated than that specified. Several FWAs and HAs have passed 12th grade or are graduates, while most CHCPs hold graduate or master's degrees.

One respondent felt that recruiting higher qualified people with medical backgrounds as CHWs was something the GOB needed to do. These CHWs could then have a career pathway.

"There needs to be recruited the quality people, it is not just the tenth grader can be recruited as CHW. It is what we are doing, and this is totally wrong. At least now there are many people who have medical background, nursing

background, midwifery background, we have to recruit those people, in that case, if we are able to do that, then we can make some sort of career planning, career pathway also. This at the policy level, we need to do that". (MoHFW senior official)

The current CHW positions are attractive as they are perceived to be secure, well-paid government jobs in an economy where employment is scarce and job security uncertain. In the case of CHCPs, the training and recognition they receive as clinical service providers also enhances their social status as well as provide them with private practice opportunities.

"Everybody is trying for government job. Especially the last 10 years, Government has increased the government salary-almost two-thirds increase. (MoHFW senior official)

"In our country, there is a very common attitude available among the people that a government job is a very good job. That you have less work and there is good pay, and payment is a monthly payment. And, if it is health work then it is more lucrative because once you start working in any facility as a provider, whether you are a doctor or not, after some point of time, maybe after one year or two years, you are considered as a doctor at the village level. You can start opening your chamber, you can do some business, pharmaceutical… I mean pharmacy business that will get a lot of new income sources as well." (Development Partner)

The CHW programmes run by NGOs reported engaging communities in the selection of their CHWs. For example, the BRAC SS is selected by the village organization, a community-based microfinance group run by BRAC, of which she herself is also a member, aged between 25 and 40 years, married and with at least primary level education. The SK cadre are residents of the respective area, 20 to 35 years old and have completed secondary education.

Similarly, Partners in Health Development, another NGO, reported consulting with elected local representatives before selecting CHWs for their programme.

The CHWs of NGOs are however project-based and are functional only for the lifetime of the project. Though they receive training during the project and could potentially be valuable skilled resources for government programmes, there is no transfer mechanism to enable them to move between programmes. Several respondents reported that there is often political interference in CHW recruitment processes, where politically influential individuals, who may not be the best candidates, are selected for the job.

The government procurement policy is very different. And they cannot pick the people from here and there. They have to go through a general recruitment process. And that recruitment process is influenced by so many things, politically influential people, people in the top… so it is difficult to even say, there are volunteers, we dealt with them, in much more brighter than a… but she or he will never come , we never take him as a government worker, because he has to come with this, so called 'process' in this process, they will be lost. So exclusion criteria will be something like that… (NGO representative)

Other administrative constraints were also highlighted in the recruitment of public sector/government CHWs. FWAs and HAs, recruited several decades ago have now retired, leaving almost one-third of these posts vacant. However, recruitment to replace these cadres has been hampered by various ongoing court cases and legal proceedings, which need to be settled before recruitment can take place.

Once they are recruited, all these CHW cadres receive pre-service training. FWAs and HAs receive three weeks' training focusing on FP methods and immunization respectively. CHCPs receive 12 weeks' training, while MPHVs receive three days' training. Refresher training for government CHWs does not seem to be regular. However, agencies like WHO and UNICEF and NGOs, often provide training for them whenever a new programme/intervention is introduced. The 2019 Evaluation of CBHS found that CHCPs believed that their basic training prepared them adequately for the job. CHCP training was perceived to be of good quality, providing a balanced mix of theory and practical competency-based training, which equips CHCPs with the knowledge and skills to provide maternal health services competently and confidently.

The CHCP has received very good training, no doubt… the three months' training of the module developed by the WHO… WHO supported government development modules, and that training was very good. After the training, they also received very practical training from the government as well. It was six weeks of theoretical training and six weeks of practical training. This helped them to do their job in a good manner. In addition to that, there are a number of NGOs who are working with the CHCP, at the initial stage and most of the NGOs are facilitating different types of capacity building, training for them as well. So, that also helped them to take more information, like around maternal health as well as nutrition and everything. So, all these capacity-building initiatives developed their confidence. (Development Partner)

However, the same evaluation also found that more refresher training was needed for these CC CHW cadres, and that while the refresher training provided responded to health programme needs, it was not always based on the capacity development needs of these cadres. MPHVs are supposed to receive orientation in order to support a ranges of services , including pregnancy, birth and death registration, immunization, FP, default tracking, any emerging or re-emerging disease, and population data collection (MOHFW, 2017).

BRAC's SS's undergo 15 days of basic training followed by a month's supervised attachment and practical training, which includes training on FP, pregnancy identification, and antenatal check-up, assistance on delivery, postnatal check-up, neonatal care and care of under five children. After this basic training, every SS has to attend a monthly organized one-day refresher training, which helps with the retention of their knowledge and skills.

The SKs receive basic residential training of 18 days which covers identifying pregnant woman, ANC, screening for pregnancy complication, counseling for facility delivery, offering immediate and essential neonatal care, treating ten common illnesses, identifying TB patients and providing DOTS for them, recording data for monthly and annual report preparation. The training also focuses on supervisory skill development. SK(s) also attend monthly refresher training (Rahman et al, 2015).

Figure 6: Training and supervision of VHW in Bangladesh

Selection

- FWA, HA and CHCP recruited through formal government recruitment processes
- Educational criteria: FWAs and HAs- eighth grade, CHCP- 12th grade
- Gender criteria: FWAs-Women, HAs- Men, CHCP- Both men and women, MPHV-Women
- No community involvement in selection process. MPHV preferably from CSG or CG, but no community involvement in selection

Pre service education

- FWAs- 3 weeks focusing on FP
- HAs- 3 weeks focusing on immunization
- CHCP- 12 weeks
- MPHV- 3 days

Certification

- No formal mechanism of registering or certifying

In-service training

- No regular government refresher training provided by UN agencies and NGOs based on different project needs

Following training, the SK and PK are attached for two weeks with a senior CHW, before being posted to the field.

Elected FWAs, female HAs and CHCPs receive six months' SBA training conducted by the Obstetrical and Gynaecological Society of Bangladesh (OGSB), which qualifies them as a Community SBA. However, very few of this cadre are currently functional.

Different respondents gave a range of responses on the certification of these CHWs post-training. While some said CHW receive a certificate upon completion of training, others said they do not. However, the general consensus seems to be that there is no formal mechanism in place for registering CHWs once they have completed the required training. KIs also noted that international training opportunities are greater for men than women.

1.6. Management and supervision

The 2019 Evaluation of CBHS found that the CHCP's job descriptions are not fully aligned with the CC concept, and job descriptions for HAs and FWAs did not include their work at the CC (MoHFW/WHO, 2019). Respondents also identified the challenges around not having up to date job descriptions for these CHWs; supervision is also difficult when supervisors are not clear about roles and responsibilities they are expected to perform.

Their job description very old and no connection with what they are doing. (Development Partner)

The CHW cadres under review were found to have different remuneration arrangements. Government FWAs and HAs are permanent staff. They are on the government payroll, receive regular government salaries and are eligible to receive benefits, like annual increments, as well as a pension after retirement. The supervisory cadres of these CHWs, the FP Inspectors (FPI), Family Welfare Visitors (FWVs) and the Health Inspectors (HI)s, are also paid and permanent government employees. However, pay is low for these cadres and is a source of low morale.

Nothing. Low pay. Low morale. When you talk to them, you don't understand how they are running their families (Development Partner)

The CHCPs are considered project staff and receive their salaries from the development budget. They are employed through a trust created for the CBHC programme and are not permanent government employees, a source of dissatisfaction according to several key respondents. In fact, CHCPs have reportedly gone on strike in the past to demand permanent government jobs.

The MPHVs are contracted on an annual basis and receive monthly performance-based incentives after successful

completion of the specified work and targets. However, concerns were expressed by several respondents on whether the use of volunteers is a viable or sustainable model, given the rising cost of living, and where securing a paid and secure job is the aspiration of many of those recruited.

"The product cost is so high in our country at this moment. So, look, people cannot do a lot of volunteering work. It's not possible. He has to run for… to improve his income. So, it's true that it's not possible to do volunteering work. It's a… still, I am not sure that MPHV will continue, because they select some young adolescent who is around 20 to 22 years old. They are selected and they are students as well. So I am not sure how much they can because they have other responsibilities as well. They have to go to their schools or colleges. So how much can they continue their work as a volunteer? After completing their education, they switch to their jobs or their businesses." (Development Partner)

Among BRAC's CHWs, the SS cadre are volunteers and do not receive any payment. However, to enable them to be financially sustainable, they are allowed to sell the health commodities and medicines provided to them as part of the programme for a small profit. They also receive special privileges in accessing loans from the microfinance group operated by BRAC. SK and PKs are paid monthly salaries. In addition, they receive performance-based incentives based on pre-set targets. One key factor that serves to motivate them is reportedly community recognition – SSs are recognized as health resources in their communities and are members of village committees for health and WASH. SKs are also seen as having clinical expertise and this enhances their recognition and status within their communities.

A key challenge mentioned by several respondents was the lack of a career ladder for all government CHWs. While in theory, FWAs could become FP Inspectors (FPIs), and HAs could become Assistant Health Inspectors (AHIs) or Health Inspectors (HIs), there are few vacancies within these higher-level posts and therefore, promotions are rare. CHWs may stay in the same position for decades, often until they retire, which reportedly affects their motivation. Similarly, no career path is available for CHCPs either.

"Once you are a health worker you are health worker forever. Like HA, family welfare assistant they are in the government system. But HA they can gradually climb, they can become… they remain HA, but their salary is increasing, every year, some increments. But motivation is very low." (Donor agency)

One senior government official expressed the view that CHWs are low level staff with no formal professional qualification and therefore do not qualify to have a career path.

"Career planning is for the career people, who have the career. They are basic worker. A basic worker cannot be a specialist." (MoHFW senior official)

BRAC's CHWs do not have a career path either. However, BRAC has helped the children of some CHWs to get subsidized education in BRAC's university and to access higher education degrees.

There is a clear hierarchal supervisory system, with FPIs, AHIs and HIs supervising FWAs and HAs respectively. These are in turn supervised by Union level officials. CHCPs are also supervised by Upazilla level authorities on administrative issues and by Sub-Assistant Community Medical Officers (SACMO) and medical officers on technical issues.

However, several challenges were highlighted related to these supervision mechanisms, which often renders supervision ineffective. One key challenge is that supervision is often carried out for administrative and reporting purposes only and does not provide technical support and/or mentoring.

"And these were not technical at all, they would just take the report and administrative." (Development Partner)

"Supervision relates to the mentoring also. And mentoring, we are not very, actually working on this mentoring part." (MoHFW official)

"Nobody goes to check whether she or he has gone to the field to advise or support the woman in the family." (Development Partner)

Robust supervision and coordination mechanisms are critical for effective and efficient service delivery, especially when community-based services are being provided by both the health services and FP departments in parallel for the same catchment population, as well as by BRAC and other NGOs. Respondents indicated that this coordination between the FWA and HA, and their programmes of work is often lacking because they have different supervisors.

"For HA, they have their supervisor AHI, I mean assistant health inspector and also on top that they have health inspector, who is working under upazilla manager, in the upazilla health complex, is called EHFPO, who is responsible for monitoring their activities. Under those two-tier. In FP, under, from the upazilla, they have the UFPO, upazilla FP officer, then they have FP inspector. And that FP inspector is supposed to supervise FWA. So two different." (Development Partner)

"We don't have a public health nurse position at the district level. No, there is no single person responsible for coordinating all the health workers." (Development Partner)

"The system in supervision is divided. A FP, union level FP inspector he can supervise only the FWA and not the HA. And AHI he is there he can only supervise the HA and not the other two people. So, Union level supervision is not working and also from the sub-district level that means Upazila- FP officer cannot supervise a CHCP no authority. So that is why I am saying we need to think at the policy level, how to integrate." (NGO representative)

These supervision challenges could also be related to FWAs and HAs absence from the CC, a finding highlighted by the 2019 Evaluation of CBHS. That evaluation found that FWAs and HAs were not always on duty in the CC as per the schedule, and only a small percentage (12 per cent) of users were aware which days in the week HAs or FWAs would be available at the CC. The part-time presence of HAs and FWAs was a constraint to the availability and continuity of services at the CC.

Some respondents also mentioned that while supervisors receive training, they often lack the resources and motivation to provide effective supervision. There are no accountability mechanisms linked to supportive supervision. Often, lack of transport is a constraint to the provision of supervision.

"Definitely government provide training for supervision monitoring, but problem in our country is there is no structured mechanism, accountability mechanism for supervision and monitoring. And also, resources like if someone has to supervise they need vehicle or transport support, that is lacking. And the amount that government provide, that is not motivating people to go to field and supervise. That's is the big problem. Always. Remains challenge for supervision." (Development Partner)

The availability of monetary and human resources to provide effective supportive to the large number of CCs across the country was seen as a barrier. There is also a lack of clarity about who within the health system is responsible for their supervision.

"We have to have a very streamlined supervision. That is also a great challenge and because the number of these facilities is greater than the existing number of our tertiary, secondary, primary health facility level. So currently, through the operational plan, the fund is going through this... through Upazila health system and to, but, I think there is a lack of coordination, lack of responsibility in the mainstream of healthcare professional, about the CCs. So, this is one of the factors. Another factor is that they don't have any time to look after and supervise the CCs. And another factor, they do not have enough people to look after things." (Development Partner)

On the other hand, BRAC seems to have a streamlined system of supervision. The SK, who receives dedicated supervisory skills development training, is responsible for the direct technical supervision of 10 SSs, with the support of other BRAC staff. Since SSs charge for their services and submit receipts for these, records of these transactions and the inventory of their supplies are used by BRAC to monitor them and provide supportive supervision.

Some female cadres are supervised by male supervisors, for example the FWA, who are all female, have male supervisors, which may affect the quality and depth of the supervision provided.

1.7. Integration into and support by the health system and the community

As described above, and based on responses from the respondents interviewed, CHWs are well integrated in the health system through the network of community clinics all over the country. The FWA, the HA and the CHCP are considered an integral part of the formal health system. Indeed, the National Strategy for CHWs refers to them as: "the community terminal of the health care organization of Bangladesh". These CHWs are expected to provide facility based and domiciliary and community-based preventive, promotive and curative care, and also contribute to data collection.

A major challenge in the integration of CHWs in the health system, raised by several respondents, was the complete exclusion of urban areas. Historically, health in urban areas has been under the Ministry of Local Government, not the Ministry of Health. While BRAC CHWs cater to urban slum dweller populations, government CHWs are not present in these areas. With rapid urbanization and the growing slum dwelling population, this was seen as a key challenge that would need to be addressed in the immediate future.

1.7.1. Availability of medicines and supplies

Individual CHWs receive supplies of medicines and commodities from the Upazilla level, which in turn is supplied through a streamlined government procurement and supply system. Buffer stock are reportedly available at the regional level and are supplied based on need. Several respondents reported that supply was usually adequate and stockouts were infrequent and minimal. The CBHC evaluation report however highlights medicine shortages as a key factor affecting the quality of care in Community Clinics.

1.7.2. Data collection and use

A key role of CHWs is to contribute data to the Health Management Information System (HMIS). All CHWs collect data to feed into different levels of the HMIS. FWAs collect paper-based data in registers, though recently in some areas, the use of tablets is being piloted in a move towards an electronic health information system. CHCPs have been provided with laptops and are contributing data to the DHIS-2.

However, almost all respondents shared that there are several challenges with the data management system. Power scarcity in rural areas means that CHWs have to sometimes travel to nearby urban centres to charge their electronic devices. Facility-based data are maintained through the DHIS-2, but community-based data systems are reportedly not as strong. One key challenge is that the data systems between the DGFP and the DGHS are not integrated or interoperable; resulting in parallel reporting systems. In addition, the FWV's reporting is through a different system and is not integrated with the reporting of the FWAs. Also, reporting is not based on individual unique IDs, thus making aggregates unreliable and causing difficulties in making sense of the data.

Because we know they have this DG FP has a different MIS system, health services has a different MIS system. Even community health care programme has an MIS system. So, it is very difficult to harmonize and to reduce the duplication of the data. So, not only the service unification, also the information unification is also necessary. (Development Partner)

But we have no individual recording, so we have no IP for individual number. So, there can be duplication - even for health, it's nutrition. If when you come to the CC, I am saying you can come five times and I am counting you as 5, because we don't have an individual tracker. Unless we have individual tracker, this trouble will continue. (Development Partner)

BRAC has a strong community-based information system, where data collected through its CHWs is used to monitor and supervise their programmes. However, this again is a parallel system that does not feed into the government HMIS. A respondent from BRAC reported that they are now making a greater effort to improve this situation.

We are interested to share data with government and government also interested to share, to get BRACs data because their community data is very poor. So, currently the Ministry of Health producing only the facility-based data and some community-based... very few. So, they are really working... would like to work with us. (BRAC representative)

1.7.3. Community integration and engagement

In addition to interfacing with the formal health system, CHWs also interface and engage with communities. However, some informants felt that the deployment of HAs and FWAs, historically domiciliary service providers, to the CC, is compromising community-based service provision, especially in hard-to-reach areas where these populations have limited access to facility-based care.

While there does not seem to be any formal community engagement mechanisms or spaces for FWAs and HAs, such mechanisms have been set up for the CC. Each CC is supported by a CG, which is in turn supported by three CSGs. These groups are intended to be the bridge between the community and CC. The 2019 Evaluation of CBHS found that most CG members perceived their role to be: "to monitor the opening hours of their CC so that services could be provided according to schedule; to encourage the use of the CC by community members; to inform community members about available services; and to assist in addressing problems faced by the CC (payments for cleaners, guards, electricity bills, repairs)." But their ability to support in this area was limited. KIs reported that when the CC receives medicine and supplies, the Chairperson of the CG is supposed to be present to verify their arrival and receipt. MPHVs are selected from within the CG and CSG and are expected to support the CC with facilitating meetings of these groups (MoHFW, 2017).

CGs are reportedly more active and meeting more regularly than CSGs 9MoHFW/WHO, 2019). This was also the view of some respondents, who reported that these groups are not functioning very effectively and tend to be more active when involved in an NGO or development partner supported activity.

Community Support Group especially is meant to be a forum of representatives group of the area. But these forums are not quite active. So, you want to really translate any kind of agenda or any messaging, you need to really keep this groups vibrant and active. So that support is not... unless, you have a development partner and an NGO supported activity there, you'll find much of these groups are not... (Development Partner)

CCs have mechanisms to mobilize resources from the community. CGs can set nominal charges for services to be paid by clients on a voluntary basis. These funds are then used for local expenses like the maintenance of the clinic.

NGO CHW programmes reach areas that the GoB-supported programmes do not. BRAC seems to have much more of a community-based presence, in both the rural and urban areas, since their CHWs are drawn from the local community.

1.8. Private sector involvement in CHW programmes

The CC itself is described in policy documents as a "unique example of public-private partnership" as the land for the CC is donated by the community, the construction, service providers, medicines, and other inputs are provided by the GoB, with management responsibility shared jointly by both the GOB and the community (MoHFW 2017).

All respondents agreed that the for-profit private sector had grown tremendously in the country in recent years. However, this sector is unorganized and largely unregulated. It does not provide any preventative and/or promotive services, focusing on curative services. Some respondents also described the implications of dual practice on services; where public sector doctors also operate or work in private facilities after government working hours, with community-based health providers sometimes receiving monetary commission to refer clients to these private facilities. These respondents also reported that the absence of robust accountability mechanisms is a key factor in preventing such practices.

While the for-profit private sector does not have much interface with CHWs, the not-for-profit private sector, such as NGOs run their own CHW programmes. The largest of these, BRAC's programme, has been described in detail in previous sections. Several respondents however felt that BRAC ran a parallel system that did not engage with government systems. BRAC's representative, while agreeing with this concern, justified this by citing the weak community presence of government CHWs.

Theoretically yes (duplicating government's work) but practically not. Because for 6,000 households there is one CC and in one CC, one FWA, one HA is there. And how many of them visits? If you see the DHS, you will find that the household visit rate is very low. So theoretically, they basically... the household visits from the CHW of government is very low. So that is there. The system is... like in paper you will see the system is there but ideally they're not visiting. (BRAC representative)

1.9. Financing for CHW programmes

Respondents suggested that the government needed to provide additional finances to allow for the recruitment of additional CHWs to fill existing CHW vacancies and address shortages in the community clinics.

Because in some places there are no family welfare assistants, so one family assistant is doing the work of three. We have nine wards, so basically we are saying that there is a need for 42,000 something, 500 something – same with HA, 42,000 – CHCPs as well. So they are saying that if the CC remains the same, we will have 100,000 something, 62 something. But if the government wants to increase CC per ward – one then we need to have 1,24,000 CHWs in this country.

Most respondents reported that financing for the government community-based programmes comes largely from domestic resources, with development partners providing funding for the overall health sector through the 2017-2020 HPNSP. Some indicated that more financing was needed.

Government financing for the CBHC programme and the CCs almost doubled between 2012 and 2018 and constituted about 0.21 per cent of the national budget and 3.84 per cent of the health budget in 2017/18. About half the budget was allocated for salary and allowances for CHCPs, while medicines expenses constituted nearly 30 per cent of the budget. In 2017/18, the share of the budget allocated for training was less than 6 per cent, of which 23 per cent remained unspent. The budget share and spending on repairs and maintenance (about 1 per cent), and supervision and monitoring were very low (0.21 per cent and 0.22 per cent, respectively) (MOHFW/WHO, 2019).

The Health Sector Support Programme is a multi-donor trust co-financed by four development partners: the Department for International Development (DFID), Global Affairs Canada (GAC), the Government of the Netherlands, and Swedish International Development Agency (SIDA). Disbursement of funds is based on a disbursement-linked indicators (DLIs) modality, a financing mechanism that ties funding directly to the delivery of results upon verified achievement of the DLIs agreed between the World Bank and the MOHFW. One of these DLIs is related to the availability of midwives for maternal care. Apart from these sources of financing, United Nations' agencies also support projects which involve the provision of community-based health services and the use of CHWs.

1.10. Gender

Most CHWs in Bangladesh are female. The current sex composition of the different CHW cadres in Bangladesh is:

- FWA, all women.
- HA, mostly men.
- Community Health Care Provider (CHCP) both men and women – 60 per cent women. (There was some contradiction among different respondents on this, with one development partner saying there were more men than women.)
- MPHV, predominantly women.
- CSBA, all women.

1.10.1. Gender issues at the family and household level

Gender norms within the family were reported to be changing with time. There is a greater acceptance of women working outside the home. However, women still need permission to work from their husbands and/or their in-laws if they are already married and residing with them when starting work as a CHW. Such work outside the home can be done only in 'acceptable' situations, e.g. there is no family acceptance for a woman to work as a CHW in a post far away from the home. Even though more women are allowed to work, they do not always have control over their earnings. Childcare is seen as a woman's primary responsibility and CHW drop-out due to pregnancy and childbearing is quite common.

1.10.2. Gender issues at the community level

The FWAs mainly provide services to women, while HAs are mainly responsible for immunization. Cultural and gender norms influence who can provide what services. For example, ANC is provided mainly by female CHWs; the provision of such services by males would not be accepted. The type of services provided by females and males can vary across the country, for example, service provision for women by male CHWs such as blood pressure and blood tests may be accepted in western areas of the country, and in cities like Dhaka, but would not be acceptable in areas such as Sylhet or Chittagong.

CHWs are in a prime position to address gender issues in the community but they need to have the appropriate training to do this. One aspect of the work of the MPHV is to identify and refer women who are experiencing GBV.

CHWs may face challenges in the community in addressing issues that are gender-sensitive, for example when talking about adolescent sexual and reproductive health and rights issues or in talking to men about FP. Some respondents suggested that mothers-in-law hold power in a traditional society like Bangladesh, and they need to be involved in discussions around issues like FP.

Overall, society was reportedly becoming more conservative, and more regressive gender norms, such as women wearing a veil, were being adopted as a result of a more stringent interpretation of religion. Bangladesh was reported to be a male-dominated society, and women are not encouraged to go to health centres to seek health services. A range of socio-cultural issues and power dynamics are at play and need to be addressed to improve women's' utilization and uptake of services.

1.10.3. Gender issues at the health system level

A number of gender issues are evident at the health system level. In terms of the selection of CHWs, the criteria used for the selection of the different CHW cadres are sex-specific. For the FWA post, women are recruited, with one development partner suggesting that the main reason women only are recruited for this post is because it is a low-paid job. The selection of CHWs for training is linked to educational attainment, and for many women, their access to further education is constrained due to gender issues and they are not always able to continue at school. Female FWA are seen as more acceptable to the community where they can go to women's homes and collect information from them.

The CHW supervisory cadres, consisting of HIs and FPIs, are all men. It was reported that this was because historically, only men fulfilled the educational requirements for these positions. This is no longer true, as there has been great improvement in women's educational levels. However, women are still excluded from these supervisory posts as they are not considered suitable for these roles. There is a perception among policymakers that as these posts are at upazilla level and may be some distance from the women's place of residence, women recruited in these positions would need to be provided with security when they travel. The mobility of female CHWs is limited compared to men, due to prevailing

gender norms and family demands on their time. Female CHWs are unable to use vehicles like bikes etc. unlike men, which also affects their ability to take up supervisory roles that require them to travel.

All of the BRAC CHWs are women, and although BRAC prefers that all its supervisors are women, in reality, only about half are women. This is because women often have to leave their jobs once they have children due to family pressures. Also, a supervisor needs to be able to travel around and because of gender norms, a woman's mobility may be limited. BRAC also prefers to select married women as CHWs, as an unmarried CHW may have to move residence once they are married. The BRAC CHWs who are working in urban areas face safety issues when travelling to the slums after dark, and often have to be accompanied by a male colleague. The GlaxoSmithKline-supported CHW programme also has women in supervisory positions.

The CSGs include both men and women. However, except in places where there is active NGO support, these groups are not active.

Training opportunities seem to be provided equally to both male and female CHWs, even when the training requires travel. Development partners prioritize women CHWs for training, however, one informant reported that males were given preference for international training.

Female CHCPs, once they get married, are not able to reside in the clinic premises – because of patrilocality they have to move to their in-laws' home after marriage. This often results in them having to resign and leave their posts. There does not appear to be mechanisms in place to enable them to retain their jobs and transfer to a post near to their new homes. CHWs can face sexual harassment, especially when staying 24/7 in the community clinic premises, from co-workers or from the community. Many CHWs do not report such harassment and if they do, only report it informally.

In terms of career progression, there are few opportunities for any of the current CHWs. However, as the CHW cadres are predominantly female, this is gendered. According to one development partner, FWAs can be promoted to FWVs.

There is a gender-based division of roles and responsibilities among CHWs. FWAs predominantly deal with women and HAs with immunization. Pregnancy and delivery are seen by policymakers as a women's matter. In fact, one development partner said it was only because there were female CHWs that the country was able to achieve its FP goals. FWAs are not trained in communicable diseases or NCDs related work. The CHCP job description is the same for women and men, however, the services provided by male and female providers vary based on community acceptability. For example, male CHCPs will not do abdominal examinations during ANC visits.

There is no pay difference between male and female CHW within the same cadre, although the MPHVs, who are volunteers, are predominantly female.

Newer CHW programmes were seen by respondents to be more gender-transformative. For example, in the past, only males were allowed to become supervisors, but newer cadres like the CHCPs give equal opportunities to men and women and prioritize women for these roles. NGO-supported CHW programmes, such as those supported by BRAC and GlaxoSmithKline, have shown that women can successfully undertake a supervisory role.

Maternity leave varies for temporary and permanent staff. Permanent staff, such as FWAs, are entitled to six months' leave. However, in practice this may be dependent on their supervisor. Temporary CHWs, such as MPHVs who are in voluntary positions, do not get paid maternity breaks. And there are no day-care facilities available in hospitals.

The services provided by, and the behaviour of, CHWs are also influenced by their own individual gender norms and values. For example, some will not provide counselling on male methods of FP or when counselling on nutrition, they will not address the issue of women eating after everyone else in the family.

Gender intersects with other axes of inequity like caste, poverty, education, and disability. Gender discrimination was reported to be less of an issue in some communities, and there is reportedly better acceptability if the CHW is from the same community.

GBV programmes are provided at higher-level facilities, and in the CCs by CHCPs also.

1.10.4. Gender and CHW policy

When assessed against WHO's gender-responsiveness scale (WHO, 2011), different aspects of the CHW policies and programmes were found to fall along different levels of the scale. At policy level, the gender equity strategy, gender-responsive budgeting and the gender-NGO stakeholder participation unit, are all examples of gender-transformative policy. Other examples of gender-transformative policies and practices in CHW programmes, include providing equal opportunities for training, with some preferential treatment for women in training, implementation of community-based programmes to address GBV; and representation of women in community support groups. NGOs were seen to be role models in pioneering gender-transformative policies and practices through their CHW programmes.

However, several aspects of the current CHW programme were found to be gender-unequal. CHWs are predominantly women and suffer disadvantages as they are poorly remunerated, with MPHVs working on voluntary basis. In addition, there are few career progression opportunities. The fact that supervisory positions are filled mostly by men is also gender-unequal, as is the rationale on which this is based such as women's lower educational levels, relative lack of mobility and need for safety. CHW cadres like FWAs, who deal predominantly with women are trained only in maternal health and FP, and not in other areas like NCDs, thus denying such services to women who preferentially seek care from female CHWs. CHWs receive limited training on gender and they may themselves perpetuate gender inequality in community-based activities through their own gender norms and values.

Development partners see the need to ensure that gender cuts across all the programmes; however, there is limited

progress on this. Policy and policymakers were also described by many development partner respondents as gender-blind and not responsive to suggestions on gender. Women are recruited as CHWs, but there is no provision in CHW-related policies for the remuneration, mobility, and the safety of such CHWs. CHCPs post are open to men and women equally, but the programme ignores some of the disadvantages that women may face in fulfilling this role and does not make provisions to address them. For example, women CHCPs face difficulty competing with men in the recruitment process, they may not be able to get a transfer to another post when they have to move after marriage, and they may face sexual harassment when they are required to stay on the CC premises.

Where both men and women are eligible to apply for a particular post, one respondent reported that women may be at a disadvantage because of their sex. Affirmative action is required in such cases. Given the key role they play in PHC strengthening and their acceptance and position within the community, CHWs need to be given appropriate gender training to enable them address gender and social inclusion issues in their communities and promote equal access to all services for all individuals, irrespective of factors such as gender, location, ethnicity, disability or age.

More women are taking up senior positions within the government. However, career progression is influenced by politics, and leadership often comes with power. Workplace safety is not very evident in the policies, but safety concerns are often used to underestimate what women can do. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex (LGBTQI) issues figure only in the context of HIV/AIDS. Bangladesh is a conservative society, and there is reportedly no space for these conversations around other genders and sexualities.

Some aspects of the CHW programmes were gender-specific/gender-sensitive. The selection of CHWs based on sex considered gender norms in society and the division of roles and responsibilities based on the sex of the CHW was also gender-specific.

2. Policy and system support improvements to optimize CHW programmes

2.1. Improving system support

The section responds to KEQ 2 and provides an overview of the polices and system support that respondents identified will be needed in Bangladesh to optimize CHW programmes to better serve maternal and newborn health, and to respond to post-Astana and/or PHC (PHC) reforms. KEQ2 seeks to assess actual or prospective country level commitments linked to the Astana Declaration and/or planned or ongoing PHC reforms, and the implications for existing CHWs policies and system support and the roles and responsibilities of CHWs involved in the provision of RMNCAH services.

While Bangladesh has not articulated any specific post-Astana commitments, its health policies and strategies are focused on achieving UHC and the SDGs. The optimization, harmonization and re-envisioning of CHW programmes and the role CHWs can play in achieving these goals is a key focus of ongoing health policy discourse at the highest level and is articulated in the recently developed national strategy for CHWs.

Several challenges were identified that affect CHWs' performance and their provision of RMNCAH services. Suggestions for addressing some of these challenges were shared by key respondents and are described below.

One area that needs immediate attention is the current CHW workload and the need to mitigate the effect this is having on effective coverage and the quality of services. It was felt that in order to reduce the burden on CHWs, action on a number of areas were required, including addressing the high level of CHW vacancies, revisiting the mandated target populations that CHWs are expected to cover, and using the MPHVs to increase coverage. In addition, it was suggested that these MPHVs, currently being piloted in 19 subdistricts, could be scaled up so that they could take on some of the roles and responsibilities undertaken by the FWAs and HAs.

I can see one of the major problems is the number of households they are covering. So, we have to reduce their workload and at national level, whenever we design any programme, we feel, I mean they the frontline worker, they will be able to implement our programme and agenda, so they are now over-burdened with different programmes, with different priorities. And also, for long time so many positions remain vacant. So that is one problem, at the same time, their workload. Initially, though they were designed for 6,000 population, this is also, I mean I believe this is also high burden workload for them. So, for ensuring effective coverage, maybe multi-purpose health volunteer could be one of the solution but still, one government should concentrate to fill up the existing position and also look at their number of household, number of population they are covering. They should be re-designed. (Development Partner)

Initially each FWA and HAs, were covering 800 households, in a certain period of time, in a cycle, maybe in three months cycle. Now somebody has to cover 1,500 households, 1,600 households. That is too much and then they cannot do the quality job. (Development Partner)

This suggestion is also reflected in the 2019 National Strategy for Community Health Workers, where based on the projected increase in population and revised norms for household coverage (500 HH/CHW), an estimated 124,000 CHWs will be needed by 2030 (MoHFW, 2019). The strategy proposes that these CHWs would be equally distributed between the DGHS and DGFP. The strategy also suggests that this recruitment of additional CHWs should be done over three phases – in the short- (within two years), mid- (within five years) and long-term (by 2030).

Another suggestion to address CHW shortages was to create a pool of CHCPs based at divisional level who, with specialized training, could be used as cover while others are on leave or to undertake supportive supervision and mentorship.

Another thing is that, maybe, if you think about that, we can recruit some 10-person additional CHCP as a reserve. That means you can put them at the district level. So, they will work as CHCP, these people will work at the CCs level. And that reserve pool ultimately, the director or divisional

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director can mobilize when the community CHCP wants to leave, to get leave. Or if they want some mentorship and they want some supportive supervision, this reserve people can do it. Even if there is some vacancy, the division can engage those people. But the one of the things I'm suggesting that this reserve pool should be trained, they should have a specialized training because they will treat as a reserve pool to do coaching and mentoring to these people. (Development Partner)

One area where the national strategy for CHWs is contentious is the recommendation that unmarried girls should not be given priority for employment as a CHW, as they may leave the community after marriage. This recommendation was seemingly justified in relation to promoting community acceptability. Some development partners expressed their discomfort with this recommendation as it was gender-discriminatory. Instead, mechanisms to allow CHWs to transfer to their new home may be more gender-equitable.

Because marital status for recruitment, that is very discriminatory. Like I am, whether I'm married or unmarried for recruitment criteria as a CHW, that is discriminatory. (Development Partner)

The national strategy also spells out a clearer supervisory structure for CHWs, an area identified as a challenge by several respondents. It also suggests measures to improve supervision, including appropriate supervisor-supervisee ratios, adequate training for supervisors, and the use of observation, performance data and community feedback.

Another area that key stakeholders identified as needing improvement is that of community engagement and 'ownership,' and the role of the CHCP in promoting this. It was felt that stronger community engagement would also serve to strengthen local accountability systems and the use of community representatives to monitor service provision, manage absence and CHW performance. Given the importance of community engagement, the expectation for clinic time verus time in the community needs to be reviewed.

I think the most important challenge is community engagement, to keep the community engaged from beginning, to develop ownership, among the community, so that's an important issue…. So to involve them it depends upon the capacity of the CHCP and also the guidance from local management, not that everything is from head office. (MoHFW consultant)
It is difficult to prove whether a government health worker

is referring a patient to the private facility. These are all... unless there is a local level accountability system. So, this will not come through a national system, but that's why local accountability systems are very important. And we have some experience, especially working with elected representatives. If they can provide this kind of oversight, they can then get all this information. They know who's working, who is not working, who's referring from where, they are the local people. So that I think is a long-term way to look at it, how do we look at communities on accountability systems (Development Partner)

The strategy puts forward several other suggestions for community engagement, including greater community participation in the selection of CHWs, involvement in priority-setting for CHW activities, the monitoring of CHWs, and in planning and budgetary processes.

Accountability was identified as a key area affecting CHW performance, and while community-based mechanisms could lead to improvements in this area, there was the view that lack of accountability was a larger organizational culture issue and needed to be tackled through interventions at multiple levels. Improving management, monitoring and supervision, as well as recognising and rewarding good performance were some of the suggested interventions.

This is a difficult question in the context this is not about health. This accountability we could not establish in any department. There is a culture of it, so this is a national organizational culture. So, well individually it is difficult to ensure but as usual we will say that you strengthen your management capacity, supervision, monitoring. And also, you organize what I always say that there should be a mechanism for recognition, rewards as well as punishment. (NGO representative)

The lack of coordination between the multiple information systems used by the different CHW cadres and the resultant double counting and duplication of data was another challenge highlighted. The development of a system where each woman/client was given a unique ID was suggested as a way to more effectively track individual clients and harmonize the data collected.

The problem with DHIS2 is that it doesn't, we cannot track down to individual level. So, if a mother is counted here and a mother is counted here. She is counted twice, irrespective of whether they are able to exchange data whether they are exchanging is another problem. That is what they have said that it is being addressed. We are part of that work. But the only solution to this is to have a unique health ID based system. So, if you have a unique health ID, irrespective of whether it is here or here or here, we will be able to communicate and track that. (Development Partner)

2.2. Optimizing CHW programmes to respond to post-Astana requirements and PHC strengthening

One of the key improvement areas identified to respond to post-Astana requirements was addressing the emerging burden of NCDs generally as well as in relation to maternal health. CHWs are seen as having a critical role to play in this area, but it was acknowledged that further discussion is needed on how CHWs could undertake this role, given the identified CHW shortages and heavy workloads, and the system support that would be required to enable CHWs support the management of NCDs.

Changing lifestyle and urbanization, most of the things WASH and other things will remain vibrant in this country, because it is adverse effect of urbanization, so they are, health workers, support is very much needed. So somewhere, maybe service delivery system may change, but service provider is necessary. (NGO representative)

What are the emerging margins of the NCDs, you cannot ignore that even. Even for maternal health, there are increased cases of instances of hypertension, diabetes, all these. So, you cannot ignore that. The programme is also realizing the importance of the early recognition and management of the NCDs at the PHC level and there we feel that the community health worker has a definite role to play. Right now, it is not happening, but as we move forward, the community worker has a role here because they are the first line of contact there. What should be their role should be the point of discussion, and what kind of support they need from the system is also something that we need to discuss. But, definitely, they have a role. (Development Partner)

Another suggestion was to shift the CHCP's curative service onto the SACMO, who are posted at the union level. This would not only reduce the CHCP's workload but allow this cadre to focus more on preventative and promotive services.

You know SACMO? Sub-assistant medical officers. That is another cadre. So, they're a bit trained, more than the CHCP. So, if this people look for this curative services, then the overall workload will be diminished from the CHCP. They can engage more on the preventative and promotive services. That's the way we can restructure the job load of the people. And strictly follow that one. (Development Partner)

3.Prioritized measures to strengthen health policy and system support to optimize the contribution of CHW cadres to PHC.

The findings in this section respond to KEQ 3 and provide a synthesis of the key findings from KEQ 1 and KEQ2, and an assessment of the possible reforms, including gender-informed reforms, required to enhance the contribution of CHW programmes to PHC, and to ensure gender equity and responsiveness, given the country context.

Almost all respondents spoke about the need to harmonize the existing CHW workforce especially at policy level. This includes the harmonization of the different CHW cadres across government and NGO programmes. One suggestion is to map the different CHWs and their roles and responsibilities in service provision, which would help identify the areas covered and the gaps that need to be addressed.

Another suggestion involved promoting communication and coordination between the FWA and the HA themselves and institutionalizing the collaborative relationships that have been built between these cadres to improve functional integrations and harmonisation.

There is a gap in the policy level but if you go into the community level with HA and FWA there is no gap. They want to work together but the problem is there. The ministry at their level, they do not want to unify. (NGO representative)

At the field level, if we can make them talk, like this... we can strengthen this coordination, institutionalize this coordination meeting between the... macro planning meeting between these two persons (FWA and HA), they help each other. Because they are from the same community. We are going for that functional level and that helps. (Development Partner)

The National Strategy for Community Health Workers recommends the creation of uniform geographic catchment areas for the different CHW programmes and teaming up male and female CHWs cadres, so that CHWs working in the same area can provide complementary and integrated services.

One of the things that they have clearly recommended is to have a uniform catchment area, so that you have HA and FWA working in the same catchment area. So it becomes a male and female worker complementing each other. (Development Partner)

Including CHW cadres in human resources for health plans and budgets will recognize and enhance the potential contributions of CHW programmes to the overall health system and PHC in particular. Respondents suggested that collaborative and collective action was needed to assess the health system and the health workforce as a whole, from the tertiary to the community level, and to create a more functional health system at all levels that responds to the needs of the population, would enable the country to achieve UHC.

If we really want to achieve universal coverage, we need to sit together, work together and we need to go through the system, the upazila health system, the union system and the CC system and the domiciliary systems, the people who government have employed. We have to see them. We have to sit down and need to assess whether the system... how can make this system functional and how can we respond to the health need of the population of the local people. (Development Partner)

Some respondents suggested that in order to achieve the SDGs, the government needs to take a more holistic perspective and to re-envision the health system to create a comprehensive primary health system. Such re-envisioning would focus on an essential services package and the human resources required to deliver such a package, rather than organizing the health system and the health workforce around specific diseases or programmes.

I would rather say the government should think of it as the essential services package, or the PHC, other than the maternal and child health. (Development Partner)

So the point is, you know, we cannot have that disease specific or thematic positions, but we need to look at, you know, in the SDGs, we need to look at holistic approach. So that's why that discussion led into... okay, why don't we look at human resource requirements more holistically. (Development Partner)

The government needs to look at the existing structure, the role, at the higher level, the line directors, the structure at the districts, upazila and how they can support CHWs.

It was also suggested that a one-size-fits-all policy approach is not appropriate for Bangladesh, given its geographical, contextual and cultural diversity. In some areas where there are geographical constraints and cultural and social barriers to accessing and utilizing facility-based services, a continued focus on domiciliary care will be required. In others where access and utilization are better, strengthening facility-based care would be more appropriate.

And when we were developing the community health worker strategy, one of the strong suggestions that I've been making is we should not look at one size fit all strategy, particularly for community-based health workers. There are certain areas of Bangladesh where probably you know, domestic, what is it called... home-based services are no longer necessary. You know, the awareness levels are quite high, people can... the road connectivity is good, the communication is very good. And people are already seeking care. So instead of, you know, community health worker going and delivering services at home, we should look at how we can have more service delivery stations where people will voluntarily seek services. Whereas there are areas like Sylhet, where we still need the cultural, social cultural barriers. Also, geographic access is still limited. We need to think about more outreach from these kind of services. (Development Partner)

However, the provision of community-based health services across the country remains critical, especially for promotive and preventative services, and to safeguard the gains made in improving access and health seeking behaviour and to ensure that no one is left behind.

Engaging the private sector to improve the quality of care provided was another area that needs attention. CHWs need to be sure that the facilities they refer clients to will provide them with quality services.

So any programme, including community health work programme, needs to really look at how do we engage with the private sector and ensure some minimum standards of care happening in the private sector. So the community health probably has a role in ensuring that they go to the right facilities when they are seeking care. (Development Partner)

CHWs can also play an important role in engaging local entrepreneurs and community groups to mobilize much needed resources for the CC, such as utilities, cleaning services, supplies, and facility renovations.

We need to engage the private sector and, you know, it has to be done locally. Centralism will not work. So, the community health care management will be taken care by the private entrepreneurs. You know we have the bazaars, the bazaar committee, they can take care of it. So that's the community groups which will take care of fundraising, even for renovation of the facilities sort of thing, they can give if they need some umbrella - they can buy for the community health worker. So, we shared that we need to tap the resource. (Development Partner)

Reaching all populations with community health programmes will require a focus on establishing urban health structures and services and ensuring the availability and deployment of CHWs with the appropriate skills mix to these areas, for example, nutrition was highlighted as a neglected area.

So in urban areas particularly in the slum areas, CCs needs to be established. (MoHFW consultant)

Throughout the whole system, there's not a single nutrition cadre. And this area is health, nutrition and population. So it's a concern. (Development Partner)

It was felt that the government CHW programmes could work with NGOs and development partners to design and deliver innovative, high-impact, quality maternal and newborn health (MNH) interventions. Such initiatives would reach populations in the hard-to-reach areas and lead to improvements in MNH outcomes over the medium to long term.

The government can support different development partners and NGOs for innovative interactions in the hard-to-reach area so that these people can get access to the services. That is important at this moment and if we can do that … to develop and deliver some quality, innovative product to the newborn and maternal health for the hard-to-reach area, then hopefully in the next five to 10 years we can hope to see some changes, in terms of our maternal mortality and newborn mortality. (Development Partner)

Some respondents were concerned about whether ongoing initiatives, such as the introduction of MPHVs requiring long-term commitment and investment, can be sustained. This level of commitment will also be required to mobilize and invest the necessary financial and human resources to implement the National Strategy for CHWs over the long term.

The initiatives like a multi-purpose health worker, I'm not sure how much commitment is there for long time investment. It is a huge commitment, if you had to really develop that in national cadre, we are probably talking about 60,000 some community health workers. That if it is, they probably modelling it around India Asha worker model. But I don't know whether the proportionate resource commitments have been secured in the government. (Development Partner)

I mean, bringing a proper CHW, should be a political agenda. Their political agenda is to reach universal health coverage. Unless you fix this, how are you going to achieve that? When they speak, they say that okay we will achieve universal health care and universal health coverage by 20302. Then you should have the political commitment to have a proper CHW, at least and to have that in a willing environment, the CHW has to function as per your strategy. It's not only about fixing the CHW itself. You need to look at the entirety. What exactly is the Upazila manager doing? Whether his job description is supporting…(Development Partner)

Some felt that if the government is to achieve UHC it firstly needs to acknowledge the weaknesses in the current PHC system, especially around governance, efficiency, accountability, and then make the necessary political commitment to reform the system and address these constraints.

First of all, government need to admit that these are the issues. We have a big problem at the PHC system. It is accountability problem, efficiency problem and management problems and governance issues problems. And government… if recognize this problem, admit that there are problems then something as big has to be done. To address those problems. What can be done? What can they do? Because the way we are fragmented is only the Prime Minister can save us because the Prime Minister…. Our Prime Minister has saved a lot of things in this country. And now this has to be seen… someone… somewhere in the ministry at the top level has to acknowledge this. (Development Partner)

3.1. Prioritized measures to strengthen gender-responsiveness to optimize the contribution of CHW cadres to PHC

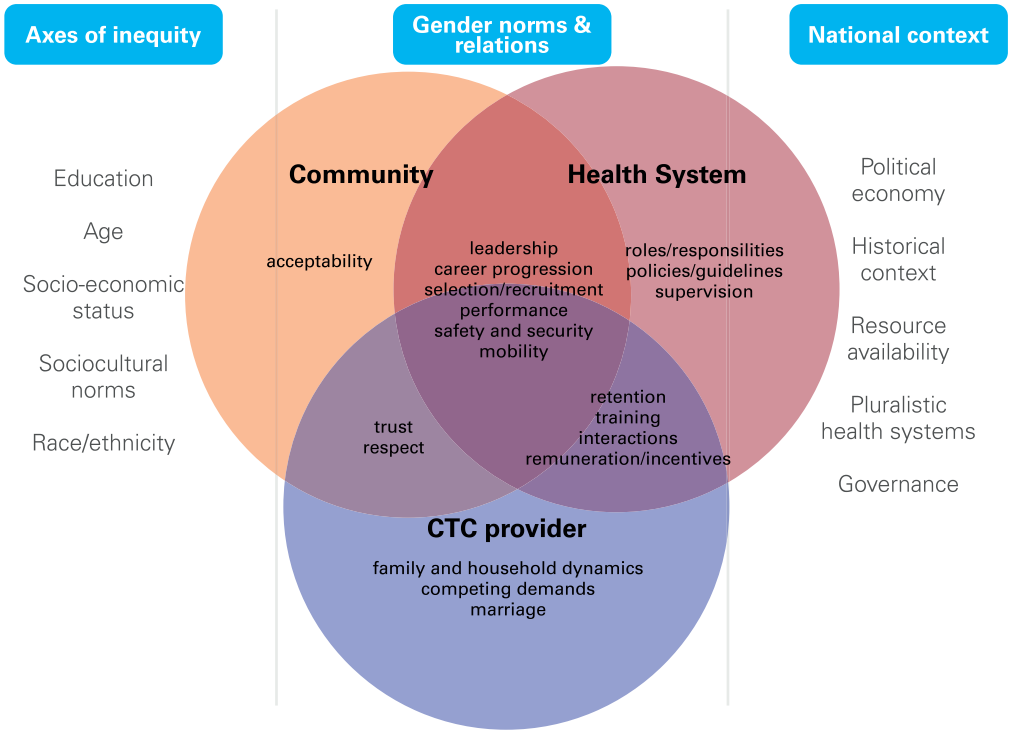
The gender component of the evaluation draws on the Steege et al (2018) conceptual framework of gender norms and relations across the levels of individual, community and health system shown below.

At the policy level, the development of a gender-equity strategy, the introduction of gender-responsive budgeting and the establishment of a gender-NGO stakeholder participation unit, are all examples of gender-transformative policy in Bangladesh. Other examples of gender-transformative policies and practices within the government's CHW programmes include providing equal opportunities for training, with some preferential treatment for women; the implementation of GBV programmes at different levels of the health system, including through CHW programmes; and representation of women in the CSGs. NGOs were perceived to be the role models in pioneering gender-transformative policies and practices through their CHW programmes.

However, while gender figures at a macro level in policy documents, it needs to be further integrated into programmes, spelled out in operational plans, with a gender focus incorporated into each stage of the project cycle (design, planning, implementation, etc), and gender-specific indicators developed to monitor outputs and outcomes, and evaluate effectiveness and impact. The guide on adopting a gender lens in health systems policy may be a useful resource for identifying GESI issues and developing benchmarks for gender across the six health systems' building blocks (Research in Gender and Ethics (2019). Gender has to be cross-cutting across ministries, it cannot be seen as the purview of the Ministry of Women and Children alone.

In addition, the following key areas are presented for policy consideration:

Health and Safety: Laws and policies that protect women who are working as CHWs are of paramount importance. Everyone deserves the right to feel safe and protected by their employer and CHWs are no different. Ensuring the safety of this cadre is important for realizing UHC and supporting female empowerment. Sexual harassment policies should be developed and implemented. Such a policy is not yet in place, in spite of a court judgement that ruled committees should be in place at the different levels. Our findings have highlighted that patriarchal relations can manifest in particularly violent ways within many settings, which should prompt the health sector to introduce health and safety measures to protect those for whom they have a duty of care.



Consider gender pay gap and equitable renumeration. Literature demonstrates that women are paid far less than their male counterparts and undertake a significant portion of unpaid work (Sen and Ostlin, 2008). Remuneration in CHW programmes varies greatly. Some are volunteers without any incentives or financial compensation, while others are formally employed and are paid salaries. Unpaid or poorly-paid positions tend to attract women who may have more limited prospects to secure other paid work (Newman, 2014). Yet by paying female CHWs a rate that is not deemed acceptable for men, CHW programmes are perpetuating the inequalities that already exist and placing women at further risk of male power. Women's unpaid caring work needs to be formally recognized and valued to break the harmful gender norms that assume women are easier and cheaper to hire and that the women's labour is more pliant.

Labelling work as voluntary also reinforces the perception that women have domestic duties they need to work around. This should be accompanied by strict recruitment criteria as programmes that promote payment of CHWs may also have unintended consequences. For example, in Mozambique, the revitalized CHW policy had an explicit preference for selecting women (MoH, 2010), but in practice communities selected men to play this role. The reasons for this are unclear but one theory is that men as breadwinners are perceived as more deserving of paid work. Again, this is an area where policies accompanied by an enabling environment towards selecting women could empower female CHWs and enable men to pursue more traditionally female roles.

Provide CHWs with career progression opportunities: Opportunities for professional development and promotion within CHW programmes are often lacking. Women and men have competing gendered responsibilities, which often affect their ability to take up training opportunities. Policies need to consider how gendered responsibilities may make it difficult for women to relocate, i.e. childcare and how women are often expected to follow their husbands, which affects their career trajectory. Career development opportunities need to be built into the system of CHW programming to encourage women to progress into higher levels of the health system and leadership positions if they so desire, and to provide the opportunity for women to input into health systems policy development (C. Campbell et al., 2009; P. C. Campbell and Ebuehi, 2011; Daniels et al., 2012; Jackson and Kilsby, 2015; Mumtaz et al., 2015; Najafizada et al., 2014).

Representation in leadership positions and roles. There is a growing body of analysis concerning gender inequities in leadership within the health sector at international, national and institutional levels showing how women are underrepresented in leadership roles (Dhatt et al., 2017). Arguably, male and female CHWs are leaders within their own community. However, evidence shows that female CHWs are less likely to advance into decision-making positions as leadership roles are often reserved for men (C. Campbell et al., 2009; Newman, 2014; Sen and Ostlin, 2008).

Gender norms and roles may impact women's and men's ability to take up leadership positions. CHWs are often unable to influence strategic level outcomes at work, such as priority setting, or resource allocation and planning (Kane et al., 2016). By giving CHWs a platform to input into policy development, including HR reforms and HR planning processes, would not only contribute to their empowerment, but also promote their role as agents of social change. In turn, this may challenge some harmful gender norms and build opportunities for them to realise their potential to build more responsive and inclusive health systems.

HR policies need to consider the gendered-specific needs of women and men. Little consideration is often given to the different family roles and obligations of female versus male workers and how these may impact employment needs and preferences. Workplace policies need to be put in place that support women in balancing paid employment and the domestic roles that disproportionately fall upon their shoulders. In addition, measures like maternity leave and sickness pay can assist female CHWs in remaining in employment.

Overall measures such as improving the agency of women through, for instance, interventions in schools and adolescent clubs, are needed. Creating the enabling environment and the resources for women and girls to exercise such agency is critical, such as the provision of restrooms and breastfeeding rooms for women in health facilities and ensuring health workers are more gender-sensitive. Health and community-based services need to be more gender-responsive and more women-friendly, for example, more or an equal number of beds for women in general wards, separate queues for women, separate toilets, separate waiting space, and adequate privacy, will reduce barriers and constraints to seeking care.

Health management information systems can identify and highlight the gendered dimensions of health outcomes. Gender-sensitive HR data should be collected and analysed, including undertaking an inventory and headcount of all CHWs, disaggregated by sex, location, seniority, and qualifications where appropriate. Health information systems should ensure the rapid collection, collation, analysis and use of these data to address inequities related to gender, social inclusion and disability.

Conclusions

In conclusion, Bangladesh has a large network of CHWs under both government and NGO programmes. In addition, there is a large number of CCs providing community-based PHC through these CHWs. When analysed vis-à-vis the policy recommendations in the WHO Guideline, several areas, such as recruitment, remuneration, training and development, career progression, supervisory mechanisms and community engagement, need to be better defined and addressed in these programmes and within the national community health system to optimize the contribution that these programmes can make. Gender is a key determinant that affects CHW programmes in the country and needs to be addressed within a national community-based health policy and programme and within the health system. While the country has taken proactive steps in drafting a National Strategy for CHWs, sustained commitment and resources will be required to implement it over the long term.

To strengthen CHW programmes in the country, there is a need to harmonize CHW programmes across different cadres, across government and NGO programmes, and across different levels of the health system. To achieve UHC and the post-Astana commitments and provide comprehensive PHC, CHW programmes have a key role in improving the provision and uptake of quality RMNCAH services, especially among unreached and marginalized populations, in both rural and urban areas.

Recommendations:

Recommendations were derived by the evaluation team based on all findings, including responses from respondents on evaluation question three. This question solicited information on prioritized measures that could be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre can make to PHC. Respondents' responses on this question were interpreted considering the other information from all data sources including the desk review. Moreover, the report including recommendations was reviewed by the relevant stakeholders, including the UNICEF staff in the country and region.

Given the system-building nature of the recommendations, all must be spearheaded by the GoB. Relevant development partners in the country should advocate as well as provide the technical support for implementing the recommendations according to their capacity.

The evaluation team presents below a key list of recommendations that have already been narrowed based on the findings. Prioritizing the recommendations further is difficult given that most of the recommendations are required to improve and enhance the policies and system to address the needs of the PHC and CHWs in the country.

Recommendation 1:

It is recommended to **assess the health system and the health workforce as a whole, from the tertiary to the community level, and to create a more functional health system at all levels** that responds to the needs of the population, to enable the country to achieve UHC. The re-envisioning would **focus on an essential services package and the human resources required to deliver such a package**, rather than organizing the health system and the health workforce around specific diseases or programmes. In some areas where there are geographical constraints and cultural and social barriers to accessing and utilizing facility-based services, a continued focus on domiciliary care will be required. In areas where access and utilization are better, strengthening facility-based care would be more appropriate. (Actor: GoB)

Recommendation 2:

Efforts should be made to harmonize the different CHW cadres across government and NGO programmes. One way is to map the different CHWs and their roles and responsibilities in service provision. That would help identify the areas covered and the gaps that need to be addressed. The government CHWs could work with NGOs and development partners to design and deliver innovative, high-impact, quality maternal and newborn health (MNH) interventions. Such initiatives would reach populations in the hard-to-reach areas and lead to improvements in MNH outcomes over the medium to long term. (Actor: GoB)

Recommendation 3:

Efforts should be made to reduce the burden on CHWs. For this, action on a number of areas are required, such as: addressing the high level of CHW vacancies; revisiting the mandated target populations that CHWs are expected to cover, and using the MPHVs to increase coverage; scale-up MPHVs so that they take on some of the roles and responsibilities undertaken by the FWAs

and HAs; create a pool of CHCPs based at divisional level who, with specialized training, could be used as cover while others are on leave or to undertake supportive supervision and mentorship. (Actor: GoB)

Recommendation 4: **Management, monitoring and supervision should be strengthened,** as well as recognizing and rewarding good performance of CHWs to motivate them. (Actors: GoB, development partner)

Recommendation 5: **While gender features at a macro level in policy documents, it should be further integrated into programmes**, spelled out in operational plans, with a gender focus incorporated into each stage of the project cycle (design, planning, implementation, etc), and gender-specific indicators developed to monitor outputs and outcomes, and evaluate effectiveness and impact. The guide on adopting a gender lens in health systems policy may be a useful resource for identifying GESI issues and developing benchmarks for gender across the six health systems building blocks (Research in Gender and Ethics (2019). Gender has to be cross-cutting across ministries, it cannot be seen as the purview of the Ministry of Women and Children alone. (Actor: GoB)

Recommendation 6: **Sexual harassment policies should be developed and implemented.** Such a policy is not yet in place, despite a court judgement that ruled committees should be in place at the different levels. Our findings have highlighted that patriarchal relations can manifest in particularly violent ways within many different settings, which should prompt the health sector to introduce health and safety measures to protect those for whom they have a duty of care. (Actor: GoB)

Recommendation 7: **Consider gender pay gap and equitable renumeration.** Literature demonstrates that women are paid far less than their male counterparts and undertake a significant portion of unpaid work (Sen and Ostlin, 2008). Remuneration in CHW programmes varies greatly. Some are volunteers without any incentives or financial compensation, while others are formally employed and paid salaries. Women's unpaid caring work needs to be formally recognized and valued to break the harmful gender norms that assume women are easier and cheaper to hire and that the women's labour is more pliant. (Actor: GoB)

Recommendation 8: **Provide CHWs with career progression opportunities.** Opportunities for professional development and promotion within CHW programmes are often lacking. Women and men have competing gendered responsibilities, which often affect their ability to take up training opportunities. Policies need to consider how gendered responsibilities may make it difficult for women to relocate, i.e. childcare and how women are often expected to follow their husbands, which affects their career trajectory.

Career development opportunities need to be built into the system of CHW programming to encourage women to progress into higher levels of the health system and leadership positions if they so desire, and to provide opportunities for women to input into health systems policy development (C. Campbell et al., 2009; P. C. Campbell and Ebuehi, 2011; Daniels et al., 2012; Jackson and Kilsby, 2015; Mumtaz et al., 2015; Najafizada et al., 2014). (Actor: GoB)

Recommendation 9: **Increase women's representation in leadership positions and roles.** There is a growing body of analysis concerning gender inequities in leadership within the health sector at international, national and institutional levels showing how women are underrepresented in leadership roles (Dhatt et al., 2017). Arguably, male and female CHWs are leaders within their own community. However, evidence shows that female CHWs are less likely to advance into decision-making positions as leadership roles are often reserved for men (C. Campbell et al., 2009; Newman, 2014; Sen and Ostlin, 2008). (Actor: GoB)

Recommendation 10: **HR policies need to consider the gendered-specific needs of women and men.** Little consideration is often given to the different family roles and obligations of female versus male workers and how these may impact employment needs and preferences. Workplace policies need to be put in place that support women in balancing paid employment with the domestic roles that fall disproportionately upon their shoulders. In addition, measures like maternity leave and sickness pay can assist female CHWs in remaining in employment. (Actors: GoB, development partner)

Recommendation 11: **Overall measures such as improving the agency of women through interventions in schools, adolescent clubs, etc. are needed.** Creating the enabling environment and the resources for women and girls to exercise such agency is critical, such as the provision of restrooms and breastfeeding rooms for women in health facilities and ensuring health workers are more gender-sensitive.

Health and community-based services need to be more gender-responsive and more women friendly. For example, more or an equal number of beds for women in general wards, separate queues for women, separate toilets, separate waiting space, and adequate privacy, will reduce barriers and constraints to them seeking care. (Actor: GoB)

Recommendation 12: **Health management information systems should identify and highlight the gendered dimensions of health outcomes.** Gender-sensitive HR data should be collected and analysed, including undertaking an inventory and headcount of all CHWs, disaggregated by sex, location, seniority, and qualifications where appropriate. Health information systems should ensure the rapid collection, collation, analysis and use of these data to address inequities related to gender, social inclusion and disability.

Annex 1 Key informant interview guide for national level informants (Generic)

Potential informants: policymakers and national opinion leaders; officials from Ministry of Health and from other relevant community health, gender, women's' affairs line ministry officials; representatives from local government and civil service; professional association and regulatory bodies; development partners and donors/funders; representatives from international and local NGOs, private sector, and training providers.

Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders of policies and systems support for CHW programmes in the country in order to enhance the effectiveness of the health care system and strengthen health outcomes in the country.
- Ensure each participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheets, consent forms, country specific CHW map, CHW definition; definition of support system; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration; figure of WHO HS Framework; and country-specific desk review findings.

Please include the following details and participant profiles as part of the recording:

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organization
- Number of months/years working in this position

For example: 'This is a key informant interview in the Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'.

A. National CHW programmes and cadres

1. What is your role in CHW programmes in this country?

2. Are the following key CHWs, (*name cadre(s)*) identified for (name the country), correct? (*Provide agreed study CHW definition, if required)*
   a. If not, which cadres should be omitted or added? (For those added, probe for their roles in Q3 below)

3. Which of these CHW cadres or programmes are you most involved with or knowledgeable about and would be comfortable discussing today?

4. Could you please describe the key roles and responsibilities of these cadres with respect to the provision of maternal, newborn, reproductive, and child health services?
   a. How would you describe the effectiveness of these CHWs currently in fulfilling their RMNCAH roles and responsibilities?

   Probe for:
   i. any other roles and responsibilities these RMNCAH CHWs might have: immunization/ polio, nutrition &/ECD, disease surveillance, WASH and/or disaster response, etc.
   ii. to determine if RMNCAH roles and responsibilities are spread across a number of cadres and how these cadres are coordinated.

   b. What factors facilitate and what factors constrain
   their effectiveness in fulfilling their RMNCAH roles and responsibilities?

   Probe for:
   i. What facilitating factors should be retained
   ii. Factors related to the individual CHW, the community and the health systems
   iii. Any gender related constraints to CHW effectiveness
   iv. Any other equity related constraints such as caste
   v. Any constraints related to competences and availability of supervisors
   vi. Recommendations to overcome these constraints.
   vii. Thoughts on how the RMNCAH roles and responsibilities of these CHWs might change in the next 10 years.

5. During our desk review we identified the following key findings related to health system support (explain/provide definition) for these CHW cadres. Do you agree with these?

Discuss any country specific issues identified through the desk review related to:

i. Selection, education & certification
ii. Management and supervision, including remuneration, contracting and career ladders
iii. Integration with health system and communities, including target pop size, data collection and use, community engagement, and availability of supplies
iv. Gender
v. Leadership and Governance

Probe for key strengths and weaknesses of the system support for these CHWs when discussing these findings.

6. What system support improvements do you think are needed to optimize the roles and responsibilities of these CHWs to better serve maternal and newborn health?
   a. How would you prioritize these?

7. During our desk review we identified the following gaps in the information we reviewed. Do you agree with these gaps? Could you provide any information or recommend any sources of information to address these gaps?

8. Provide a summary and discuss key information gaps identified through the desk review (see country snapshot summaries)

9. Is there a database/HR information system in place and maintained for CHWs in (name the country)?
   Probe for:
   i. for which cadre are data collected
   ii. the type of information collected (e.g. name, sex, age, location , cadre, training, funding source)
   iii. how the information is used
   iv. ownership and maintenance of database

8. Could you recommend any sources of information to address these information gaps?

B. Policy environment for CHW programmes

1. From the list of policy documents that we have, are there any other key policies or strategic frameworks that guide CHW programmes in (name the country)?

2. How well do the policies support the implementation of programmes related to these CHWs and the achievement of results? What are the policy gaps? Probe for any challenges to effectively translate policies into results.

3. Are there any plans to strengthen or reform programmes related to these CHWs in (name the country)? (Please describe)

   Probe for:
   i. changing roles in RMNCAH
   ii. changing roles in PHC
   iii. competing roles with non-communicable diseases
   iv. improved information systems
   v. changing nature of demographics/community structures that is likely to influence any changes in the CHW roles and responsibilities (i.e. due to patterns of regional or national migration/outmigration, security concerns, labour market demands etc.)

4. Are there any plans to strengthen or reform PHC services in (name the country)? (Please describe). Draw on any country specific information from desk review findings

   Probe for:
   i. the impact of reforms on the roles and responsibilities of these CHWs
   ii. any ongoing or planned reforms related to Astana or Universal Health Coverage

5. What policy improvements are needed to optimize the roles and responsibilities of these CHWs to:

   a. provide RMNACH services
   b. respond to Post Astana or PHC reforms?
   c. How would you prioritise these?

6. In your opinion, what do you think are the key challenges to strengthening or reforming programmes related to these CHW in (name the country)?

   Probe for the following:
   i. systems support issues
   ii. unclear roles and responsibilities
   iii. lack of policies
   iv. governance and leadership
   v. financing/resources
   vi. technical capacity
   vii. Lack of coordination

C. Gender

1. What role does gender play in the design and implementation of programmes related to these CHW in (name the country)? (Contextualise the probes based on desk review findings)

   i. Female and male CHW roles in the provision of services and take up of services by communities
   ii. CHW selection criteria for different CHW roles- RMNCAH, immunization/polio, nutrition,

&/or ECD 0-3, other disease surveillance, WASH and disaster response
iii. Community acceptability
iv. Effectiveness of CHWs in carrying out their roles and responsibilities
v. Access to training
vi. Discrepancies between prescribed coverage area/target population and what happens in practice due to HR/CHW shortages
vii. Work environment and safety
viii. Remuneration
ix. Senior/leadership roles
x. Career progression opportunities/criteria and constraints
xi. Overcoming potentially prohibitive cultural norms
xii. How other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs

2. Of the gender issues related to these CHWs that you have identified, how are these being addressed?

Probe for policies and specific system support

D. Financing and resource mobilization

1. How are programmes related to these CHWs currently financed and/or resourced?

Probe for information on the following funding streams and proportion of funding from each:
i. Government financing
ii. Donor projects/programmes (off budget)
iii. Direct budget support from donors
iv. Community resources
v. Support from NGO and private not-for profit organizations
vi. Support from private-for-profit organizations

Request any documentation to support responses

2. Are there any changes planned to financing strategies for programmes related to these CHWs and/or to improve system support?

Probe for the following:
i. increased domestic or external funding;
ii. private sector support/involvement
iii. new mechanisms for health financing (user fees, health insurance,...),

Probe for availability of financing for CHW system support including:
i. drugs and medical supplies,
ii. remuneration
iii. job aids
iv. transport and logistics support
v. IT equipment for data collection
vi. supervision and mentoring
vii. refresher training

E. Private Sector Contribution to CHWs

1. What is the private sector's contribution to the production, use and management of these CHWs in this country?

Probe for:
i. Participation of contribution of not-for-profit and for-profit private sector organizations
ii. participation of private training institutions in training these CHWs
iii. participation of health professional societies in training these CHWs

2. How could the contribution from the private sector be enhanced?

F. Additional information

- Which key stakeholders would you recommend we meet while we are in the country?
- Are there any key documents that we should review for this study?

Closure
- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

Annex 2 Key informant interview guide on GENDER for national level stakeholders

Potential informants: Informants with a special knowledge/work area of gender and CHWs – including UNICEF CO gender focal person, any gender focal persons with different ministries involved with CHWs, gender focal persons from development partners, representatives from NGOs working on gender and health.

Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders on gender issues in policies and programmes related to CHWs.
- Ensure participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheet, consent form, note on country-specific gender issues identified from desk review; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration

Please include the following details and participant profiles as part of the recording:

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organization
- Number of months/years working in this position

For example: 'This is an key informant interview in Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'.

1. Please describe briefly your current position and your work, current and previous, related to gender and CHWs.

2. In your experience, in this country (name the country), how do you think gender impacts on the work of the CHW cadres we have identified in this country (name the cadres or provide list of the cadres we are referring to)?

   Probe for:
   - I. Gender issues faced by these CHWs
     - i. at family/household level
     - ii. in the community
     - iii. within the health system
   - II. Challenges faced by these CHWs in their work due to these issues

3. You spoke about how gender impacts the work of CHWs. How do other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs?

4. At the policy level how does gender play a role in policies related to these CHWs in this country (name the country)?

   Probe for:
   - I. Selection of CHWs for training
   - II. Division of roles/services between male and female CHWs
   - III. Remuneration
   - IV. Career progression
   - V. Work environment and safety
   - VI. any focus in CHW/PHC policy on gender issues related to other genders (apart from male/female, eg. transgender) and any suggestions on how these can be included

5. At the programme level how does gender play a role in in the design and implementation of programmes related to these CHW cadres in this country (name the country)?

   Probe for:
   - I. Female and male CHW roles in the provision of RMNCHAH services by the health system and take up of services by communities
   - II. CHW selection criteria
   - III. Access to training
   - IV. Work environment and safety
   - V. Mobility
   - VI. Remuneration
   - VII. Senior/leadership/supervisory roles
   - VIII. Career progression
   - IX. Overcoming potentially prohibitive cultural norms

6. Have any specific policy measures been put in place to ensure that policies and programmes related to these CHWs are gender-responsive/address issues related to gender?

If necessary, explain that gender-responsivenes involves considering gender norms, roles and inequalities, and measures to actively address them.

Refer back to issues raised as part of previous questions. Probe for answers from Q2 i, ii, iii, and Q3 if any solutions were given).

Probe for:

I. What are the key successes of these measures in addressing gender concerns in the CHW policies/programmes?
II. What are the key challenges of these measures in addressing gender concerns in the CHW policies/programmes?
III. Can you cite any specific examples of CHW programmes in the country where policies or programmes have been/have made efforts to be gender-transformative?

If there are any issues identified in the desk review around gender for this specific country, refer to these and ask if anything has been done to address them.

7. If programmes related to these CHW in this country (name the country) were to be made truly gender-transformative, what would you suggest should happen to achieve this?

If necessary, explain gender-transformative programmes as: programmes that consider gender norms, roles and relations for women and men, address the causes of these gender-based inequities, and include ways to transform harmful gender norms, roles and relations.

Probe for:

I. Anticipated barriers, challenges and suggested solutions in implementing these suggestions
II. Equal pay
III. Equal access to training
IV. Equal access to promotion opportunities
V. Overcoming cultural norms/barriers

8. With regards to community health and/or PHC reforms being planned in this country (name the country), what are the measures being put in place to make programmes related to these CHWs responsive to gender concerns?

I. What would be your suggestions to make them more gender-responsive?
II. Anticipated barriers, challenges and suggested solutions in implementing these suggestions

Additional information:

- Which key gender informed stakeholders would you recommend we meet while we are in the country (name the country)?
- Are there any key gender related documents that we should review for this study?

Closure

- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

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Annex 4: Ethics Approval letter

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Friday, 30 August 2019

Dear Ms Caffrey,

Re. Research Protocol (19-037) ***Evaluation of South Asia's current Community Health Workers policies and system supports, and their readiness for Community Health Workers' expanding roles and responsibilities within Post-Astana national health care strengthening Plans***

Thank you for your letter providing the necessary in-country approvals for this project. I can confirm that the protocol now has formal ethical approval from the LSTM Research Ethics Committee.

The approval is for a fixed period of three years and will therefore expire on 30th August 2022. The Committee may suspend or withdraw ethical approval at any time if appropriate.

Approval is conditional upon:

- Continued adherence to all in-country ethical requirements.
- Notification of all amendments to the protocol for approval before implementation.
- Notification of when the project actually starts.
- Provision of an annual update to the Committee.
  Failure to do so could result in suspension of the study without further notice.
- Reporting of new information relevant to patient safety to the Committee
- Provision of Data Monitoring Committee reports (if applicable) to the Committee

Failure to comply with these requirements is a breach of the LSTM Research Code of Conduct and will result in withdrawal of approval and may lead to disciplinary action. The Committee would also like to receive copies of the final report once the study is completed. Please quote your Ethics Reference number with all correspondence.

Yours sincerely

Dr Jamie Rylance
Co Chair
LSTM Research Ethics Committee

unicef

for every child

Country Report for Bangladesh

UNICEF Regional Office for South Asia (ROSA)