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Reimagining The Role Of Community Health Workers In Saarc Countries

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ABBREVIATIONS: Community Health Workers (CHWs), South Asian Association for Regional Cooperation (SAARC), Accredited Social Health Activists (ASHA), Sanitation and Health, Education in Village communities through improved Awareness and Knowledge of Prevention/Management of Diseases and Health Promotion (SEVAK), Surgical Accredited and Trained Healthcare Initiative (SATHI), Lady Health Worker Program (LHWP)

KEYWORDS: Community Health Workers, enhanced role for CHWs, standardized curriculum, South Asian Association for Regional Cooperation

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*CHWs are extensively deployed in SAARC, but lacks standardized curriculums.

*We make a case for enhancing the scope of CHWs due to shifting disease paradigm.

*Recent years have seen a new type of CHW for NCDs, unmet mental, and surgical conditions.

*It will have to be determined whether CHWs should be specialized or multi-functional generalist.

*Adequate compensation models via property tax or insurance should be explored.

ABSTRACT

Following the Alma Ata declaration, SAARC countries have established their workforce of community health workers (CHWs) to address primary healthcare needs. Initially focused on maternal and child health, the countries now confront a changing healthcare landscape characterized by non-communicable diseases (NCDs), mental health issues, and surgical conditions. These developments have led to the emergence of specialized CHWs tasked with managing NCDs and mental health concerns, prompting a reevaluation of the balance between specialization and maintaining a generalist approach. The effectiveness of CHWs during crises hinges on critical factors such as standardized training, opportunities for career advancement, and equitable compensation. This view point makes a call to introduce a specialist category of CHW to align with evolving healthcare requirements in SAARC countries.

SUMMARY POINTS

*CHWs are extensively deployed in SAARC, however, there is a need to implement uniform and standardized curriculums, career advancement, provide timely, and fair salary.

*Recent years have seen an exponential increase in non-communicable diseases, mental, and surgical conditions.

*We make a case for introducing a new cadre of specialized CHWs due to shifting disease paradigm.

*Adequate compensation using fee for service, public-private partnership, non-cash incentives, and alternative payment models via property tax or health insurance should be explored.

INTRODUCTION

The Alma Ata Declaration of 1978 emphasized the pivotal role of Community Health Workers (CHWs) in global healthcare delivery, employing a "bottom-up" approach adopting community empowerment and participation in decision-making, fostering collaboration, and local ownership of health initiatives.[1] Across the South Asian Association for Regional Cooperation (SAARC) countries, comprising Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka, CHWs initially concentrated their efforts on maternal and antenatal care, making significant progress in improving maternal and child health outcomes (Table 1 & Figure 1).[2]

However, disease patterns in SAARC[3] countries are evolving, marked by a rising prevalence of non-communicable diseases (NCDs), ongoing challenges with infectious diseases, increasing recognition of mental health issues, and unmet surgical conditions. Non-communicable diseases (NCDs) are the leading cause of death that kill 41 million people each year, equivalent to 71% of all deaths globally. Within low and middle-income countries (LMICs), NCD-associated premature mortality accounted for 46% of 31.5 million recorded deaths. The prevalence of NCD-attributed deaths as a proportion of total mortality within South Asian countries varies significantly, ranging from 44% to 84%.[4]

The Disease Control Priorities Network (DCPN)[5] provided a comprehensive assessment of mortality and morbidity attributable to surgically preventable conditions in LMICs. Within South Asia, contributions to the burden of surgically preventable conditions were noted as 50.46%, 32.49%, 26.67%, and 33.35% for neonatal and maternal diseases, congenital anomalies, digestive conditions, and injuries, respectively. This region also had higher avertable disease

burden rates, i.e., DALYs per 100,000 population than the overall LMIC rate.[6] A modeling exercise revealed that 5.3 billion people globally lack access to emergency and essential surgical, obstetric, trauma, and anesthesia (SOTA) care; of these, over 30.2% of the total people lacking access live in South Asia.[7]

Mental disorders are highly prevalent across the globe, especially in LMICs[8] where these account for 8.8% to 16.6% of the total burden of diseases. Based on the national health surveys in India and Nepal, the WHO reports that the lifetime prevalence of mental morbidity is 13.7% in India and 10% in Nepal.[9] A meta-analysis reported that the total prevalence of mental disorders in India is 58.2 per 1,000 people. In Bangladesh, the prevalence of mental disorders varied from 6.5% to 31.0% among adults. The epidemiological data related to mental disorders for Sri Lanka, Afghanistan, and Bhutan is limited.[10] The majority of people with a mental disorder in LMIC receive no treatment for their disorder due to shortage of mental health professionals.[11]

In this viewpoint, we make a case for creating a new cadre of CHWs to tackle rising incidence of NCDs unmet mental and surgical conditions in SAARC countries. The insights gained from the implementation of specialist CHW initiatives can inform similar efforts across the Global South.

TRADITIONAL ROLE OF COMMUNITY HEALTHCARE WORKERS IN SAARC COUNTRIES

CHWs have traditionally focused their efforts on maternal and antenatal care. In Pakistan, the Lady Health Worker Program (LHWP) established in 1994 focuses on maternal and child health, successfully reducing maternal and infant mortality rates.[12] In Nepal, a network of 52,000 Female Community Health Volunteers (FCHVs)[13] contributes to maternal and child health outcomes but faces challenges in trauma surgeon distribution and mental healthcare resource

allocation.[14] Bangladesh relies on over 100,000 CHWs (Shashthya Shebikas) for essential healthcare, leading to notable improvements.[15] In India Accredited Social Health Activist (ASHA) program, launched in 2005, has played a pivotal role in reducing maternal mortality rates.[16]

SPECIALIST COMMUNITY HEALTH WORKERS

Community health workers have gone beyond their assigned roles in providing child and maternity care in times of crisis. During the COVID-19 pandemic, CHWs swiftly and efficiently delivered medications, protective equipment, and supplies to hospitals and facilities, which was widely praised by national and international authorities.[17] India has seen the introduction of a new type of CHW; SEVAK - Sanitation and Health, Education in Village communities through improved Awareness and Knowledge of Prevention/Management of Diseases and Health Promotion[18 19], and SATHI - Surgical Accredited and Trained Healthcare Initiative.[20] The SEVAK project focuses on the prevention of diabetes and hypertension. The SATHI project demonstrated how CHWs with culturally sensitive and low-cost short training could convert 60% of unmet to meet surgical needs.[21 22] A grass-roots community-based program in rural India was associated with substantial increase in equitable contact coverage for depression and improved mental health literacy.[23]

Despite local successes, these models of specialized CHWs focusing on particular disease processes need to be replicated in other parts of SAARC countries to test for effectiveness and cost efficiency.

FINANCING OF THE COMMUNITY HEALTH WORKERS

Financing the salary and benefits of CHWs is critical to ensure they are appreciated and attract a new generation of healthcare workers. It must also be emphasized that the majority of CHWs are females, so it becomes imperative that the yardstick of social justice is applied for fair compensation.[24] During the COVID-19 pandemic, the adaptability of funding mechanisms and the shifting of certain funds played a crucial role in bolstering financial support for addressing operational needs in public facilities. This flexibility enabled the reallocation of funds to critical functions such as contact tracing, ensuring a dynamic and effective response to the evolving demands of the pandemic.

The WHO suggested that domestic governments should financially match donor investments in Primary Health Care (PHC) programs, including salaries and medicines. Additionally, the WHO proposed a 0.5% increase in external aid for health, a 10% shift from non-PHC to PHC activities, and a 3% GDP increase in government spending (with a 4% increase in the health share) could elevate public spending from 0.9% to 1.9% of GDP by 2030, generating additional funds for deployment of CHWs.[25]

Governments could also explore public-private partnership (PPP) finance options[26] to fund CHW programs. Public-private partnership options capture private investment flows and increase private sector partnerships with public and philanthropic organizations to facilitate efficiency, accessibility, and innovations in the global health market.[27]

Public Private Partnership strategies[28]: There are several sub-categories that can be explored such as (i) catalytic investment in which governments can attract private investment by initiating projects and providing initial capital to kickstart CHW programs. This seed funding can

incentivize private sector participation, and ensure the viability of the program in its early stages. (ii) partial credit guarantees in which donors can offer partial credit guarantees to commercial lenders, mitigating the risk of default on loans provided for CHW initiatives. This mechanism encourages commercial investment by reducing the financial risks associated with funding such programs. (iii) Socially Responsible Investments (SRIs) which align private sector investments with social impact objectives, including funding CHW programs. Investors screen projects based on predefined environmental, social, and governance criteria, ensuring that investments contribute to positive societal outcomes. (iv) Social Impact Bonds (SIBs) which facilitate private financing for CHW programs, with a focus on measurable social impact. Investors provide upfront capital, and if the project achieves predefined outcomes, the government repays the investment with interest. Conversely, if the project fails to meet targets, the government bears no financial obligation, and investors incur losses.

Innovative payment models to employ CHWs are being tested in the United States which could potentially be applied to SAARC countries.[28] These include pay-for-performance models for CHWs who meet specified goals; payment models that compensate CHWs that help patients overcome pre-determined risk factors; supplementary amount to primary care practices that employ CHWs, and finally a salary derived from local property taxes, such as in Bernalillo County, New Mexico, that allow regions to employ CHWs.

Incentive design from ASHAs in India: Based on the analysis and best practices for incentive design from ASHAs in India, two key changes are recommended for the CHWs' sustainable increase in their financial compensations; firstly, enhancing the design of the incentives model to better align with desired outcomes, and second, improving the implementation of incentive

tracking and payments. To address these challenges, potential solutions include separating lumped incentives into individual ones for specific outcomes, with progressive weighting for high-impact activities, or offering smaller incentives for initiating a series of outcomes, followed by larger incentives for completion which could improve maternal and newborn health outcomes.[29]

POLITICAL RIGHTS FOR CHWS

It is not clear if CHWs should be allowed to function as trade unions - in India, ASHAs are paid a paltry $35 per month and not provided personal protective equipment during the pandemic.[30] Recently, there has been an increase in salary and benefits, however, it is not been uniformly implemented in the country and has been the result of agitation politics.[31] In Pakistan, in 2013, LHWs were regularized and considered government employees with all additional benefits of paid sick leaves, pensions, etc. Nonfinancial incentives, such as preferential access to loans or healthcare services, played an important role in motivating and improving the effectiveness of CHWs' healthcare delivery services in Bangladesh.[32] This suggests that a combination of both types of incentives could enhance CHWs' satisfaction and effectiveness in delivering healthcare services. Progress has been made in that aspect the Global Fund recently became the first major international organization to mandate adequate salaries for CHWs.

CONCLUSION

CHWs are extensively deployed in SAARC, however, there is a need to implement uniform and standardized specialist CHWs curriculums which could be modeled after the SATHI

curriculum.[22] Implementation of these measures will increase the ability of governments to deploy them in times of crises, such as pandemics, and natural catastrophes. There is also a recognition that CHWs are essential for achieving the SDGs, UHC, and ending preventable child and maternal deaths.[33] Unfortunately, CHW programs have been an 'underfunded afterthought'.[34]

In our opinion, there is a need to introduce specialized CHWs in SAARC countries to reduce the burden of NCDs, mental disorders, and unmet surgical needs. The effectiveness of specialized CHWs have been shown in small trials. There is a need for large scale trials to show that specialized CHWs are cost effective.

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Table 1: SAARC countries and their CHWs status

Sr. no.	Country	Child and Maternal CHWs	Surgical CHWs	Mental CHWs	NCD CHWs
1	Pakistan	Yes (LHWs)	No	No	No
2	Nepal	Yes (FCHVs)	No	No	No
3	Bangladesh	Yes (SS)	No	No	No
4	India	Yes (ASHAs)	Yes (SATHIs)	Yes	Yes (SEVAKs)

LHW: Lady Health Worker

FCHV: Female Community Health Volunteers

SS: Shashthya Shebikas

ASHA: Accredited Social Health Activists

SATHI: Surgical Accredited and Trained Healthcare Initiative

SEVAK: Sanitation and Health, Education in Village communities through improved Awareness and Knowledge of Prevention/Management of Diseases and Health Promotion

Figure 1: Current status of CHWs in SAARC countries