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Frontline Health Project

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The Community Health System in Bangladesh: An Overview

BANGLADESH HEALTH SYSTEM

Bangladesh is divided into eight administrative divisions, 64 districts, and 545 sub-districts, known as upazilas (formerly referred to as thanas) (1). Each rural area within an upazila is divided into union parishads and mouzas, which are further divided into villages (1).

The Ministry of Health and Family Welfare (MOHFW) has an extensive health infrastructure that is pluralistic and follows the country's administrative pattern. Union parishads are the smallest administrative unit in rural areas. At the lowest administrative level, traditional healers, non-qualified allopathic practitioners, and community health workers (CHWs) are typically the only providers available (2). The different administrative levels, their governance, and associated health facilities are detailed in **Figure 1**.

COMMUNITY HEALTH WORKER STRATEGY

In September 2019, the MOHFW endorsed the proposed *Bangladesh Strategy for Community Health Workers (2019-2030)*. Save the Children in Bangladesh led the strategy's development, and a consortium of community health stakeholders provided input. The objectives of the strategy are three-fold: Provide guidance and a framework for selection, training, certification, recruitment, and deployment of CHWs; strengthen the management and supervision structure of CHWs; and establish systems for CHW integration into and support by health systems and communities (3).

The strategy provides guidelines for CHWs' selection, certification, capacity building, linkages with primary health structures, supervision and monitoring, and improving performance. A national action plan is underway for implementation of the strategy (3).

Figure 1. Bangladesh Health System Structure

The *Bangladesh Strategy for Community Health Workers (2019-2030)* is cited by the MOHFW as a complementary document of the *Bangladesh National Health Workforce Strategy* (BNHWS) which was deployed in 2015. The health workforce strategy focuses on five major areas related to the health workforce: planning, capacity development, recruitment, performance management, and information systems (3).

GOVERNMENT COMMUNITY HEALTH WORKER PROGRAMS* IN BANGLADESH

Currently active CHWs in Bangladesh are employed by the MOHFW or local non-governmental organizations (NGOs) (3). CHWs employed by the MOHFW at the union, ward, and village levels are divided into three categories: Health Assistants (HAs) that fall under the Directorate General of Health Services (DGHS), Family Welfare Assistants (FWAs) that fall under the Directorate General of Family Planning (DGFP), and Community Health Care Providers (CHCPs) that are based at community clinics (CCs) and fall under the purview of DGHS.

CCs operate at the village level in the health system, and are regarded by the MOHFW as the first contact point for essential health services. There is approximately one CC for every 6,000 people in Bangladesh (3).

Ideally, the location of each CC is set so that at least 80% of the population it serves is able to reach the clinic in a 30-minute walk (4).

The profiles of FWAs, HAs, and CHCPs are distinct. FWAs were introduced by the government in 1976, and their work focuses on family planning provision and referral for clients for antenatal and postnatal care (ANC and PNC). HAs were introduced as a formal CHW cadre in 1995, with added responsibilities over the years. Prior to being recognized as a formal cadre, many HAs were working as vaccinators or malaria control workers. Their work was expanded to focus on immunizations, Vitamin A supplementation, and detection and treatment of pneumonia, diarrhea, malaria, and tuberculosis. CHCPs were introduced in 2010 to staff CCs. Their main responsibilities are to provide ANC and PNC, treat cases of pneumonia, diarrhea, and anemia, and provide family planning, mainly in the form of providing second doses of injectable contraception (4).

Traditionally, HAs and FWAs provided services solely at the household level and through outreach clinics, however, a recent government directive stipulated that they are stationed alongside CHCPs at CCs to provide services for three days a week in addition to continuing their household visits (4). More information about FWAs, HAs, and CHCPs is shown in **Figure 2**.

Figure 2: Characteristics of Community Health Care Providers (CHCPs), Health Assistants (HAs), and Family Welfare Assistants (FWAs) in Bangladesh

**This brief focuses on CHWs working in rural areas in Bangladesh, where they provide the majority of their services. CHWs working in urban areas are recruited separately by local governments and NGOs.*

NON-GOVERNMENT COMMUNITY HEALTH WORKER PROGRAMS IN BANGLADESH

The profiles of CHWs working for different NGOs are distinct, with different names, designations, selection criteria, job requirements, and remuneration. This brief will focus on the largest NGO employer of CHWs in Bangladesh—BRAC—which is also the largest NGO in the world, and operates in nine countries. In Bangladesh, there are an estimated 100,000 CHWs employed by BRAC (2).

BRAC began CHW programming in the early 1970s by adopting the Barefoot Doctor approach first used in China and applying it to male paramedics. In the early 1980s, BRAC shifted its focus to lesser-trained female CHWs who were familiar with health promotion and disease prevention, and began the Shasthya Shebika (SS) Program. Shasthya Shebikas (SSs) conduct monthly household visits and provide health education to families on topics including nutrition, safe delivery, family planning, immunizations, and water, sanitation, and hygiene (WASH). They also provide referrals to government health centers and BRAC clinics. SSs work part-time in the afternoons, and receive no salary. They sell health commodities such as soap, sanitary napkins, and basic medicine to generate a small profit in order to sustain their work (4).

SSs are supervised by Shasthya Kormis (SKs), higher-level CHWs which receive a monthly salary. In 2008, BRAC introduced Newborn Health Workers (NHWs) and Community Skilled Birth Attendants (CSBAs) as additional cadres of CHWs to improve maternal, neonatal, and child survival services. NHWs and CSBAs are responsible for providing newborn follow-up and care and providing skilled births within the community, respectively. All together, SSs, SKs, NHWs, and CSBAs provide a range of services to pregnant mothers, neonates, and children under five (4).

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Photo credit: BRAC. 2013. An SS working under BRAC's Alive & Thrive program counsels a mother on breastfeeding.

Photo credit: Save the Children Bangladesh. 2014. A mother is educated on nutrition by a health worker at a community clinic.