THE REPUBLIC OF THE UNION OF MYANMAR

MINISTRY OF HEALTH AND SPORTS COMMUNITY BASED HEALTH WORKER POLICY

2020

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COMMUNITY BASED HEALTH WORKER POLICY

ACCESS TO HEALTH FUND

FOREWORD

Based on the principle that all people have the right to the highest attainable standard of health and no-one-left behind, the Ministry of Health and Sports (MoHS), Myanmar has been trying to provide comprehensive health care services to the community including those in remote and hard to reach area.

While the competent, motivated and supported health workforce is the spinal column of every health system, community based health workers (CBHW) have been recognized as a vital component of primary health care since the Alma Ata Declaration in 1978 up till Astana Declaration in 2018 as they serve as a bridge between communities and health care system. Like other developing countries, we have convincing evidence validating the valuable contribution of CBHWs in delivering basic and essential life-saving health services, particularly for under-served vulnerable populations. It is also found that they still need to be duly recognized, integrated, supported, and rewarded for the crucial role they play for the local community.

This CBHW policy is intended to support MoHS's long-term vision for delivery of health services to all communities, including how community-based services can complement outreach and facility-based health services as a part of a wider health system that leverages all types of health providers to deliver a Basic Essential Package of Health Services to the entire population. It has been formulated based on international and in-country experiences and evidence, with contributions of various stakeholders including Basic Health Service Professionals and even CBHWs, to facilitate proper integration of various kinds of CBHWs in our country's health system.

As this policy outlines a comprehensive, institutionalized approach to community health, it will contribute to fully leveraging the potential of this substantial health workforce already existing in the country as well as ensuring efficient use of resources, necessary oversight and quality service provision in the future. It contains pragmatic policy statements and implementation approaches for improving and strengthening their recruitment, selection, education, management, career development, supervision, and system support.

So, I'd like to encourage all health care professionals in country as well as our national and international partners for collaborating and applying those policy guidelines in implementing respective health care programs. Bridging health systems and communities through collaboration and partnership in line with this policy, we would make progress for achieving Sustainable Development Goals and Universal Health Coverage in Myanmar.

19.8.20

Dr. Myint Htwe
Union Minister
Ministry of Health and Sports
The Republic of the Union of Myanmar

PREFACE

Recalling the Declaration of Alma-Ata and the Declaration of Astana from the Global Conference on Primary Health Care (Astana, 2018), participating governments reaffirmed people-centred health care services, recognized a role for community health workers in the delivery of Primary Health Care, in reducing inequities in access to essential health services, particularly in under-served or vulnerable populations. Health systems in Myanmar are undergoing considerable change and National Health Plan 2017-2021 calls for all health workers (whether community-based, outreach-based or facility-based) involved in the delivery of health promotion, prevention and treatment services to be fully recognized and institutionalized within the health system to ensure efficient use of resources, necessary oversight and quality service provision.

The development of the Community Based Health Workers (CHWs) policy is therefore very timely and represents a significant milestone in our efforts to improve the health status of our population especially at rural area. This policy was developed in close partnership with all stakeholders in the health sector, including our key development and implementing partners and it is also to be implemented in close partnership with them. Department of Public Health is committed to supporting the implementation of this important policy which will serve as a guide to implement the government's policy of access to essential health services at community level.

I hope that State and Regional or Township Health Management teams will make optimal use of this policy to enhance their capacity to address the priority health problems that we are facing every day mainly in the communities. The Department of Public Health also acknowledges and thanks to the concerted effort of working groups, individuals, and organizations/institutions at different levels of the health system that have worked assiduously to endorse this important policy for rural health development in the country.

Dr. Soe Oo
Director General
Department of Public Health/ Department of Medical Service
Ministry of Health and Sports

ACKNOWLEDGEMENTS

The Community Based Health Worker (CBHW) Policy was developed under the leadership of H.E. Dr Myint Htwe (Union Minister, Ministry of Health Sports) and guidance of Professor Thet Khine Win (Permanent Secretary) and Dr. Thar Tun Kyaw (Director General, Minister's Office). Dr. Tin Nyunt (Director General, Traditional Medicine, Retired), Dr. Kyaw Nyunt Sein (Deputy Director General, Disease Control, Retired), Dr. Nilar Tin (Deputy Director General, Planning Department, Retired) and Dr. Than Win (Deputy Director General, Public Health, Retired) provided advice to the policy development and endorsement process.

The CBHW Policy was produced through the dedicated efforts of many individuals across the country. Consultations through workshops and community visits were conducted in Kayin State, Sagaing Region, Shan State, and Ayeyarwady Region. These consultations included Township Medical Officers and Basic Health Staff from over 30 Township Health Departments along with more than 100 representatives from local Civil Society Organizations, Ethnic Health Organizations and other Non-Governmental Organizations as well as more than 120 CBHWs, Village Administrators and other Community Leaders. While it is not possible to list all of these individuals by name, their contributions—grounded in the experience of providing primary health care services and promoting health in their communities—provided the foundation for formation of this policy.

Appreciation to the CBHW Core Group and Working Group for their tremendous efforts in developing the CBHW policy and Ms. Alyssa L. Davis (Community Health Systems Consultant) for providing technical support to the CBHW Core Group and Working Group.

Special thanks to the Deputy Director Generals/Directors and Deputy Directors of Kayin State, Sagaing Region, Shan State, and Ayeyarwady Region Health Departments for their leadership in convening consultation workshops in the respective States and Regions.

Finally, thanks to the 3MDG Fund for providing resources for the situation analysis and policy development process as well as the many Non-Governmental Organizations, Professional Associations and United Nations Organizations for providing valuable inputs during consultations. Each and every person who contributed is appreciated for their great efforts to make the policy development process possible for the benefit of all communities in Myanmar.

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ACRONYMS

AMW	Auxiliary Midwife
AOP	Annual Operational Plan
BHS	Basic Health Staff
CBHW	Community Based Health Worker
CCM	Community Case Management
CH	Child Health
CHW	Community Health Worker
EHO	Ethnic Health Organization
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunization
GF	Global Fund
HIV	Human Immunodeficiency Virus
HLPU	Health Literacy and Promotion Unit
HMIS	Health Management Information System
HRH	Human Resources for Health
HRMS	Human Resources Management System
ITHP	Inclusive Township Health Plan
LMIS	Logistics Management Information System
MNCH	Maternal Newborn Child Health
MRH	Maternal Reproductive Health
MoHS	Ministry of Health and Sports
NAP	National AIDS Program
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NIMU	National Health Plan Implementation Monitoring Unit
NMCP	National Malaria Control Program
NHP	National Health Plan
NTP	National Tuberculosis Program
RDT	Rapid Diagnostic Test
SOP	Standard Operating Procedure
TB	Tuberculosis
THD	Township Health Department
THWG	Township Health Working Group
UHC	Universal Health Coverage
V/WHC	Village/Ward Health Committee
VTHC	Village Tract Health Committee

DEFINITIONS

The following key terms are defined and used as follows throughout this policy document:

Term	Definition
Health Care Providers	Describes persons who are providing health care services for preventing illnesses and treatment or promoting health of people such as MoHS health staff, EHO health workers etc.
Community Based Health Worker	Describes a health worker who performs a set of essential health services, receives standardized training outside the formal nursing or medical curricula, and has a defined role within the community and the larger health system.
Health Staff	Describes a health worker who provides facility-based or outreach-based health services to the community as a staff member of Ministry of Health and Sports or Ethnic Health Organizations or partner organizations.
Community Based Health Care (People-Centered Care)	An approach that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. Encompasses not only clinical encounters, but also health of people in their communities and their crucial role in shaping health policy and health services.
Township Health Working Group	Inclusive Township level health governance structure formed by the Township Health Department, Ethnic Health Organizations and partners to plan and monitor health service delivery to all communities through coordination across all stakeholders in the Township.
Primary Health Care	A whole- society- approach to health and wellbeing centered on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental, and social health and wellbeing.
Integrated Health Services	Health services that are managed and delivered so that people received a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care according to their needs throughout the life course.

EXECUTIVE SUMMARY

The **Alma Alta Declaration** (1978) and **Astana Declaration** (2018) defined a role for community health workers in the delivery of Primary Health Care and emphasized the need for all types of health workers to respond as a health team to the expressed health needs of communities. There is growing global consensus that efforts to bridge health systems and communities through collaboration and partnership will be key contributors to the achievement of a Sustainable Development Goals for health and Universal Health Coverage.

PAHO/WHO

The International Conference on Primary Health Care at the Lenin Convention Center in Alma-Ata in September 1978.

RATIONALE

To extend service delivery to all communities, the National Health Plan 2017-2021 calls for all health workers (whether community-based, outreach-based or facility-based) involved in the delivery of health promotion, prevention and treatment services to be fully recognized and institutionalized within the health system to ensure efficient use of resources, necessary oversight and quality service provision (regardless of whether the health workers are voluntary or salaried).

VISION

Every person in Myanmar has access to a health worker in their community who is trained, equipped, supplied, and supported to provide a basic package of health services and appropriate referral as a bridge to the wider health system.

OBJECTIVES

1. To harmonize all relevant Ministry of Health and Sports departments, divisions, and programs around a national long-term vision for leveraging Community Based Health Workers as members of the primary healthcare team and extending the health system to the community level.
2. To align all relevant Development Partners to support the institutionalization of Community Based Health Workers and invest resources to strengthen national health systems.
3. To aid in the reform of existing laws, regulations, procedures, and programs to ensure efficient use of resources, necessary oversight, and quality service provision to all communities.

POLICY STATEMENTS ACROSS FOUR PRIORITIZED AREAS OF AN INSTITUTIONALIZED APPROACH

1. Role and Service Package

a. Community Based Health Workers are members of the primary health care team and act as a bridge between local health staff and communities within the Myanmar health system.

b. Community Based Health Worker role covers basic health services including data collection, health promotion, prevention, and treatment and referral functions according to MoHS' SOP/ guidelines.

c. Community Based Health Workers provide an integrated package of health services in order to respond to community health needs and enable coordinated service delivery within the health system:

Auxiliary Midwives:	Provide a basic package of health services to the community, similar to, the services provided by Midwives.
Community Health Workers	Provide a basic package of health services to the community, similar to the services provided by Public Health Supervisors-2.

2. Coordination, Collaboration and Governance

a. Standardized formats for Community Based Health Worker reporting supports service delivery and contribute to the national Health Management Information System. Only data with a management system in place and defined purpose for use is collected and reported.

b. Data is regularly reported (i.e. at least once every three months) by the Community Based Health Workers to the local respective health committee and supervising local health staff. Data is compiled, reviewed, and used for planning at the local health facility and Township levels.

c. Meetings are held regularly (i.e. at least once every three months) at the local health facility with Community Based Health Workers and health staff for reporting, supervision, and coordination purposes. Joint meetings with different types of health staff (e.g. MoHS, EHOs and Partners) at the local level are held, so that health service coverage to all communities can be coordinated.

d. State/Region, Township and Village level governance structures are established or strengthened to enable effective coordination of Community Based Health

Workers and service delivery to the community level. Respective committees at Village/Ward level are established/ revitalized to provide oversight on recruitment, selection, performance and enable social accountability from the community level.

e. National level governance structures and mechanisms are established for coordination across the relevant departments, divisions and programs of the Ministry of Health and Sports and externally with all relevant stakeholders for implementation of the Community Based Health Worker policy and to develop SOP/Guidelines for CBHWs.
f. National level governance structure shall define medical ethics, rules and regulations, uniforms, registration and deregistration, duties, and responsibilities of CBHWs.

3. Recruitment, Selection and Distribution

a. Recruitment and selection are done through a defined, inclusive, systematic, and transparent process by the respective committee at village/ward level
b. Standardized selection criteria are used to identify individuals who are trusted by the community, motivated to serve the community, and speak the local language(s) of the community.
c. Joint planning, prioritization and oversight of recruitment are led by the Township Health Working Group in coordination with all relevant stakeholders. Township Health Departments maintain and update the current mapping and registration of all Community Based Health Workers in the Township in coordination with all stakeholders.
d. Distribution guideline of one Auxiliary Midwife and one Community Health Worker per community is applied with consideration for population density and catchment area (i.e. 1000 population or 2 square miles) as well as prioritization for vulnerability, including geographic and social access to health services and disease burden (e.g. communities without a health facility, migrants, Internally Displaced Persons).
e. All Auxiliary Midwives and Community Health Workers receive the same initial standardized training respective to the cadre, which is provided in relevant local languages bilingually where needed to enable selection of individuals who know the local culture and language(s) of the community to be served.

4. Supervision, Supplies and Support

a. A standard set of essential medicines and supplies are appropriately provided to all Community Based Health Workers.
b. Transportation cost is provided for Community Based Health Workers according to national level governance structure's guidance or instructions, to regularly attend meetings at the local health facility and for local health staff to conduct visits at the community level for purposes of supervision and coordination.
c. Standardized financial support is provided according to national level governance structure's guidance or instructions, based on participation in terms of collaboration with local health staff.

d. Non-financial incentives are provided, including annual recognition ceremonies and career development opportunities in line with national level governance structure's guidance or instructions.
e. Performance is reviewed on a regular basis with positive reinforcement or corrective measures taken accordingly.
f. Supportive supervision by local health staff is enabled through allocation of resources, provision of standardized tools and use of information technology
g. Partnership-based supervision approaches are supported by all stakeholders. (i.e. MoHS, EHOs, Donors, and Partners) with findings compiled and shared to the Township level.

1. BACKGROUND

1.1. INTRODUCTION

The **Alma Alta Declaration** (Article VII) and the **Astana Declaration** defined a role for community health workers in the delivery of Primary Health Care and emphasized the need for all types of health workers to respond as a health team to the expressed health needs of communities. The global health community is increasingly recognizing the need for collaboration between community health workers and professional health workers in order to strengthen health systems improve the delivery of essential services and ensure an effective continuum of care. There is growing consensus that such efforts to bridge health systems and communities through collaboration and partnership will be key contributors to the achievement of a Sustainable Development Goal for health and Universal Health Coverage in years to come. The World Health Assembly's adoption of the Framework on Integrated People-Centred Health Services highlighted that for health care and coverage to be truly universal, it requires a shift from health systems designed around diseases and health institutions towards health systems designed for people, with people.

Over the past year, the Ministry of Health and Sports (MoHS) has embarked on an evidence-based and consultative process to develop a Community Based Health Worker (CBHW) Policy for the country. This policy is intended to support the MoHS' long-term vision for delivery of services to all communities, including how community-based services can complement outreach and facility-based health services as a part of a wider health system that leverages all types of health providers to deliver a basic Essential Health Package of Services (EPHS) to the entire population. A CBHW Policy that outlines a comprehensive, institutionalized approach to community health will contribute to fully leveraging the potential of this substantial health workforce already existing in the country as well as ensuring efficient use of resources, necessary oversight and quality service provision in the future.

1.2. RATIONALE

The main goal of the National Health Plan (NHP) 2017-2021 is to extend access to a basic EPHS to the entire population while increasing financial protection. The defined basic EPHS emphasizes the critical role of primary health care and the delivery of essential services and interventions at Township level and below, starting within the community. The NHP 2017-2021 recognizes that considerable efforts will be needed to strengthen the health system to support effective delivery of quality services and interventions. In order to extend service delivery to all communities, the NHP calls for all health workers (whether community-based, outreach-based or facility-based) involved in the delivery of health promotion, prevention and treatment services to be fully recognized and institutionalized within the health system to ensure efficient use of resources, necessary oversight and quality service provision (regardless of whether the health workers are voluntary or salaried).

Full recognition and institutionalization of health workers within the health system is defined in the NHP 2017-2021 as follows:

- Inclusion in national level policy frameworks, plans and budgets at all levels;
- Integration into HRH plans for necessary oversight, retention, and quality

  - Defining roles and responsibilities
  - Determining quantity and distribution for recruitment
  - Standardizing training in line with national policies
  - Ensuring continuous supervision, support, and performance management
  - Recognizing and motivating through standardized incentives
  - Building in the potential for employment and career development
- Integrated data and reporting that supports performance management, informs decision making and contributes to national Health Management Information System (HMIS)
- Integrated service delivery to make the most of patient contact (e.g. referral for immunization during sick child consultation)
- Supply of commodities and equipment through the national Logistical Management Information System (LMIS)
- Linkage with health governance structures from national to community level for accountability
- Inclusion of initial, recurring, and operational costs (e.g. initial training, refresher training, basic kits, replenishment of drugs, travel costs) in government budget allocations.

1.3. AUDIENCE

A comprehensive, institutionalised approach to community health can only be achieved through alignment and coordination of departments, division, units and programs within the MoHS as well as actors outside the MoHS, including Development Partners and all types of service providers (i.e. EHOs, NGO and private-for-profit). Therefore, the CBHW Policy has engaged all these vital actors throughout the development process and is intended to garner greater alignment between actors, so that all human and financial resources can be optimally leveraged for extending services to all communities and advancing UHC in Myanmar.

1.4. DEVELOPMENT PROCESS

The MoHS CBHW Core Group was formed to guide and make decisions regarding the policy development process and consisted of the following individuals: Deputy Director General Disease Control (Chair); Deputy Director General Public Health; Directors of Basic Health Staff (BHS), Child Health (CH), Health Literacy and Promotion Unit (HLPU), Maternal Reproductive Health (MRH), Non-Communicable Disease (NCD), National Implementation Monitoring Unit (NIMU); Deputy Directors/Program Managers of the National AIDS Programme (NAP), National Malaria Control Program (NMCP) and National TB Program (NTP). The MoHS CBHW Working Group was formed to carry out activities for the policy development process under the guidance of the CBHW Core Group and consisted of the following individuals: Deputy Director/Assistant Director BHS (Focal), CH, HLPU, MRH, NCD, NIMU, NAP, NMCP and NTP.

The CBHW Policy development process started with a Comprehensive Literature Review of the Situation of CBHWs in Myanmar. The comprehensive literature review was completed in December 2017 and consolidated evidence from existing documentation, while also highlighting key knowledge gaps that could be usefully addressed through further

situation analysis. Based on this need, a three-prong approach for further situation analysis was devised by the MoHS CBHW Working Group to address these key knowledge gaps by drawing on global evidence, country documentation and a series of stakeholder consultations. Under the guidance of the MoHS CBHW Core Group, this situation analysis was taken forward drawing on global evidence, in-country documentation and a series of stakeholder consultations with a focus on four prioritized areas of an institutionalized approach for the policy development as follows: 1) Service Package and Role; 2) Recruitment, Selection and Distribution; 3) Supervision, Supply and Support, including Incentives; 4) Coordination, Collaboration and Governance across the Health System and Communities.

A total of four State/Region Consultations were carried out from June – September 2018 with the respective State and Regional Health Departments, including the participation of Township Health Departments (THDs), Basic Health Staff (BHS), CBHWs and Community Representatives as well as Ethnic Health Organizations (EHOs), Non-Governmental Organizations (NGOs) and other Civil Society Organizations. Ayeyarwady Region, Shan (South) State, Sagaing Region and Kayin State were purposefully selected to include contextual factors of variation, particularly the range in the types of geography (e.g. delta, dry zone and mountainous), donor support (e.g. 3MDG, Global Fund and various bilateral donors) and service providers (i.e., Government, Non-Governmental Organization, Ethnic Health Organization and Private) in the country. The overall objective of the State and Region Consultations was to inform the development of evidence-based policy and operational options to take forward a comprehensive, institutionalized approach to community health within a range of contexts across Myanmar.

To learn from the experience and perspectives of a wider cross-section of Development Partners across the country, a Development Partner Consultation was held on 9th November 2018 in Yangon. The overall objective of this consultation was to gather feedback on the recommendations coming out of the State/Region Consultations as well as obtain additional input based on Development Partner experiences in supporting CBHWs. A final Central level MoHS Consultation with Senior MoHS Officials was held on 3rd-4th December 2018 in Nay Pyi Taw. The overall objective of this consultation was to review the combined State/Region recommendations and Development Partner feedback as well as obtain additional input for development of the policy. The CBHW Policy document was drafted by the MoHS CBHW Working Group, then reviewed for finalization and approval by the MoHS CBHW Core Group for submission to the Union Minister by the end of 2018.

1.5. POLICY ALIGNMENT

The national CBHW Policy links to and aligns with the following existing policies, strategies, and initiatives:

National

- National Health Policy (1993)
- Myanmar Sustainable Development Plan (MSDP-2030)
- National Health Plan 2017-2021
- Myanmar Human Resources for Health Strategy 2018-2021
- National Strategic Plans of All National Programs

International

- Alma-Alta Declaration (1978)
- Astana Declaration (2018)
- Sustainable Development Goals
- Universal Health Coverage
- WHO Global Strategy on Human Resources for Health: Workforce 2030
- WHO Framework on Integrated People-Centred Health Services
- WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes

2. POLICY FRAMEWORK

2.1. VISION

Every person in Myanmar has access to a health service provider in their community who is trained, equipped, supplied, and supported to provide a basic essential package of health services and appropriate referral as a bridge to the wider health system.

2.2. OBJECTIVES

1. To harmonize all relevant Ministry of Health and Sports departments, divisions, and programs around a national long-term vision for leveraging Community Based Health Workers as members of the primary healthcare team and extending the health services and system to the community level.
2. To align all relevant Development Partners to support the institutionalization of Community Based Health Workers and invest resources to strengthen national health systems.
3. To aid in the reform of existing laws, regulations, procedures, and programs to ensure efficient use of resources, necessary oversight, and quality service provision to all communities.

2.3. PRINCIPLE

The CBHW Policy will aim to apply within the Myanmar context the ten globally defined principles for institutionalization of community health [1]:

1. Engage with and empower communities to build viable and resilient community health systems with strong links to health and other relevant sectors.
2. Empower communities and civil society to hold the health system accountable.
3. Build integrated, resilient community health systems based on recognized frontline health workers.
4. Implement national community health programs at scale, guided by national policy and local systems context, to ensure impact.
5. Ensure sufficient and sustainable financing for community health systems that is based on national and international resources, includes the private sector, and contributes to reducing financial barriers to health.
6. Program to reduce health inequities and gender inequalities.
7. Ensure that communities facing humanitarian crisis receive essential health care, particularly at the community level.
8. Invest in the development of inclusive partnerships to leverage and coordinate diverse civil society and private sector actors to support national acceleration plans and enable communities to shape and support the implementation of policies.
9. Integrate community data into the health information system, including investment in innovative technologies.
10. Employ practical and participatory learning and research to identify, sustain, and scale up effective community interventions while providing opportunities for country-to-country lesson sharing and informing a shared global learning agenda.

3. POLICY STATEMENTS AND APPROACHES

Each of the four prioritized policy areas are introduced by a brief summary of relevant global guidance and a description of the current Myanmar context based on inputs gathered from global evidence, country documentation and the series of consultations conducted for the policy development. The relevant policy statements for each prioritized area are then presented and supported by approaches for policy implementation.

3.1. SERVICE PACKAGE AND ROLE

3.1.1. GLOBAL GUIDANCE	3.1.2. MYANMAR CONTEXT
Community Based Health Worker service packages and roles should respond to the needs expressed by communities [2]. Community-based delivery of services has been demonstrated to be more cost effective and equitable than facility-based delivery of services alone [3-4]. Prioritization for service packages should consider interventions that are technically sound, operationally manageable, and most promising in their potential for maximum health impact. Supply and resupply of equipment and supplies must be planned and costed during the design of the service package and role [2].	Community health needs span the areas of communicable diseases (e.g. colds, flu, dengue, diarrhea, malaria and pneumonia); non-communicable diseases (e.g. diabetes and hypertension); sexual, reproductive, maternal, newborn and child health (e.g. family planning, antenatal care, delivery, postnatal care and nutrition); mental health, substance abuse and first aid (e.g. injuries and snake bites). There are a range of health providers present in all communities, including numerous informal/untrained providers and private providers. First point of care seeking by community members is often to any provider available within the community, which can result in inappropriate treatment and absence or delay in referral. Consultation participants across all four States and Regions agreed that integration and expansion of CBHW service packages is needed to align with community health needs and the delivery of the basic EPHS.

3.1.3. POLICY STATEMENTS

- Community Based Health Workers are members of the primary health care team and act as a bridge between local health staff and communities within the Myanmar health system.
- Community Based Health Worker role covers basic health services including data collection, health promotion, prevention, and treatment and referral functions according to MoHS' SOP/ guidelines.

- Community Based Health Workers provide an integrated package of health services in order to respond to community health needs and enable coordinated service delivery within the health system:
    - Auxiliary Midwives provide a basic package of health services to the community, similar to the services provided by Midwives.
    - Community Health Workers provide a basic package of health services to the community, similar to the services provided by Public Health Supervisors 2.

3.1.4. POLICY IMPLEMENTATION APPROACHES

- Job descriptions, standard operating procedures, treatment algorithms and standard sets of supplies will be updated to reflect the integrated, expanded service packages of both AMWs and CHWs.
- Community Case Management of Childhood Illnesses (i.e. diarrhea, malaria, nutrition and pneumonia), disaster preparedness, first aid, health promotion/literacy, non-communicable disease screening/support and promotion of HIV testing/counseling etc. will be included in both the AMW and CHW role.
- Reality that antibiotics are everywhere in the country and available to everyone through many sources will be recognized with practical actions to realistically address this issue in support of the National Action Plan for Antimicrobial Resistance, including passing and implementing regulations to control private and informal drug sellers as well as effort focused on training and supervising CBHWs for rational and safe use of antibiotics according to national guidelines of MoHS.

3.2. COORDINATION, COLLABORATION AND GOVERNANCE

3.2.1. GLOBAL GUIDANCE	3.2.2. MYANMAR CONTEXT
Global evidence suggests that successful community health programs require a supportive social and policy environment for community engagement at national, district, and local levels. Policies should encourage multiple stakeholders in various parts of national and local government, the private sector, and civil society to harmonize with and support community engagement strategies [2]. Village health committees and other local management structures can be effective mechanisms to ensure local leadership, legitimacy, engagement, empowerment, and governance. Resources need to be invested to make community engagement strategies effective, including in the formation and support of community management or governance structures [5]. Partnership between communities and the health system is needed for joint ownership,	Township Health Working Groups (THWGs) have recently been established across the country and some Village/Ward Tract or Village/Ward Health Committees exist in most Townships. Most local health staffs receive some information about communities from CBHWs, but this is primarily through ad hoc meetings or phone communication since standardized reporting formats for most types of CBHWs do not exist (e.g. AMWs and CHWs). Very few local health staffs have regular engagement with Village/Ward Tract or Village/Ward Health Committees. Routine mechanisms for coordination, collaboration and governance across State/Region, Township, Village/Ward Tract and Village/Ward levels have not been established and adequately supported, thus limiting community engagement and participation in CBHW activities and the

3.2.1. GLOBAL GUIDANCE	3.2.2. MYANMAR CONTEXT
collaborative supervision, a balanced package of incentives and practical monitoring systems incorporating data from communities [7].	health system more broadly. Consultation participants consistently indicated that relationships between BHS/Hospital staff and CBHWs should be strengthened, including through regular meetings and requests for CBHWs to be warmly welcomed when coming to health facilities (e.g. when accompanying patients).

3.2.3. POLICY STATEMENTS

- Standardized formats for Community Based Health Worker reporting support service delivery and contribute to the national Health Management Information System. Only data with a management system in place and defined purpose for use is collected and reported.
- Data is regularly reported (i.e. at least once every three months) by the Community Based Health Workers to the local respective health committee and supervising local health staff. Data is compiled, reviewed, and used for planning at the local health facility and Township levels.
- Meetings are held regularly (i.e. at least once every three months) at the local health facility with Community Based Health Workers and health staff for reporting, supervision and coordination purposes. Joint meetings with different types of health staff (e.g. MoHS, EHOs and Partners) at the local level are held, so that service coverage to all communities can be coordinated.
- State/Region, Township and Village level governance structures are established or strengthened to enable effective coordination of Community Based Health Workers and service delivery to the community level. Respective committees at Village/Ward level are established/ revitalized to provide oversight on recruitment, selection, performance and enable social accountability from the community level.
- National level governance structures and mechanisms are established for coordination across the relevant departments, divisions and programs of the Ministry of Health and Sports and externally with all relevant stakeholders for implementation of the Community Based Health Worker Policy and to develop SOP/Guidelines for CBHWs.
- National level governance structure shall define medical ethics, rules and regulations, uniforms, registration and deregistration, duties, and responsibilities of CBHWs.

3.2.4. POLICY IMPLEMENTATION APPROACHES

- To establish National, State/Regional and Township level governance structures and Standard Operating Procedures to implement, monitor and oversee the CBHW Policy implementation and to develop SOP/Guidelines for CBHW.

- To conduct Joint meetings with different types of health staff (e.g. MoHS, EHOs and Partners) at the local level are held regularly (i.e. at least once every three months) for reporting, supervision, and coordination purposes.
- To establish or revitalize the respective committees at Village/Ward level to provide oversight on recruitment, selection, performance and enable social accountability from the community level.

3.3. RECRUITMENT, SELECTION AND DISTRIBUTION

3.3.1. GLOBAL GUIDANCE	3.3.2. MYANMAR CONTEXT
Recruitment, selection and distribution of Community Based Health Workers must be informed by an understanding of the health needs of the population and the operational model of the health system [2]. Clear, systematic, and transparent community participation in recruitment and selection is crucial [8]. Appropriate recruitment policies and processes improve program performance and reduce attrition. Optimal distribution depends on the timing and targeting of tasks as well as the population density and typology of the area [2].	Recruitment and selection processes are currently unclear and inconsistent, often varying based on the type of CBHW and organization providing support. In many cases, CBHWs are selected by Village Administrators, BHS/EHO Staff or I/NGO staff without transparent or systematic involvement of community members. In some cases, the THDs are not aware or informed of CBHWs recruited by INGO or National Program staff. This has resulted in a situation of duplication/aggregation of CBHWs in some communities, but no CBHWs in other communities and a lack of oversight and planning in distribution and prioritization overall.

3.3.3. POLICY STATEMENTS

- Recruitment and selection are done through a defined, inclusive, systematic, and transparent process by the respective committee at village/ward level.
- Standardized selection criteria are used to identify individuals who are trusted by the community, motivated to serve the community, and speak the local language(s) of the community.
- Joint planning, prioritization and oversight of recruitment are led by the Township Health Working Group in coordination with all relevant stakeholders. Township Health Departments maintain and update the current mapping and registration of all Community Based Health Workers in the Township in coordination with all stakeholders.
- Distribution guideline of one Auxiliary Midwife and one Community Health Worker per community is applied with consideration for population density and catchment area (i.e. 1000 population or 2 square miles) as well as prioritization for vulnerability, including geographic and social access to health services and disease burden (e.g. communities without a health facility, migrants, Internally Displaced Persons).
- All Auxiliary Midwives and Community Health Workers receive the same initial standardized training respective to the cadre, which is provided in relevant local

languages bilingually where needed to enable selection of individuals who know the local culture and language(s) of the community to be served.

3.3.4. POLICY IMPLEMENTATION APPROACHES

- A standardized format for mapping CBHWs, registration form, deregistration will be used for compilation at the Township level to inform Inclusive Township Health Plans (ITHPs) and contribute data to the Human Resources for Health Information System.
- Planning and prioritization for recruitment, training and deployment of all CBHWs in a Township will be overseen and agreed by the THWG/Township level governance structure, in order to rationalize the distribution of CBHWs with the cooperation of partners to achieve maximum coverage and equity with available resources for integrated service delivery to communities (i.e. discontinuing the inefficient and uncoordinated partner support to different types of CBHWs in one community).
- Recruitment and selection of all CBHWs in a community will be overseen and agreed by the Village/Ward Health Committee, including for continuation of support by partners to any CBHW in a community.
- Flexibility in education and age will be allowed in selection according to National, State/Regional and Township level governance structure's guidance, so the most appropriate and motivated individuals can be selected by the community in all areas of the country.
- Training curriculum and manuals will be updated to provide basic standardized training to all AMWs and CHWs according to the integrated, expanded service package of each cadre.
- Training methodologies will be competency and skill-based, including medical ethics, adequate care, good performance, behavior change counseling and community mobilization.
- All CBHWs will be registered and given registration or recognition card, which are renewable on a regular basis if the CBHW adheres to basic requirements (i.e. attending training, providing reports, and following guidelines/ethical practices).

Updated Selection Criteria for AMWs
Resident of the community; interested in health and social work; desire to stay and serve in the community after initial training; chosen by the Village/Ward Health Committee. Preference is given to women who have completed middle school education and who speak the relevant local language(s) of the community.
Updated Selection Criteria for CHWs
Resident of the community; interested in health and social work; desire to stay and serve in the community after initial training; chosen by the Village/Ward Health Committee. Preference is given to persons who have completed middle school education and who speak the relevant local language(s) of the community.

3.4. SUPERVISION, SUPPLIES AND SUPPORT

3.4.1. GLOBAL GUIDANCE	3.4.2. MYANMAR CONTEXT
Lack of supervision, supplies, and support often results in high rates of turnover in community health worker programs, which is costly in terms of health worker replacement and health system performance. Supportive supervision is an essential component of a successful community health program and is a motivating incentive, but it requires allocation of time and resources [2,8]. The standard approach of oversight from a facility-based health worker tends to be costly and difficult to implement, but alternative and complementary approaches that distribute supervision tasks (e.g. group, peer and community supervision) have been demonstrated as successful in some contexts [7,9-11]. A balanced package of financial and non-financial remuneration provided in line with expectations and workload is important for retention. Financial incentives given on a short-term, project dependent basis and primarily by donors can shift ownership away from both government and communities [2]. Opportunities for recognition and career advancement have been documented as highly motivating non-financial incentives [12-14].	Most health staff aim to provide supervision to CBHWs either once per month or once per quarter, but available time, resources and transport make this challenging. In some cases, supervision takes place during EPI and outreach visits or health facility meetings, but there are no standardized reporting forms for AMWs or CHWs, nor standardized supervision guidelines or checklists for BHS. Most CBHW consultation participants stated that they did not usually have all the supplies they need, and many indicated that they purchase supplies themselves, although some also receive supplies from BHS, EHO or I/NGO staff. Malaria and TB volunteers receive financial incentives, but AMWs and CHWs do not. When I/NGO or project-based donor support is available, then CBHWs often receive transport allowance to attend meetings. Exclusive dependence on donor resources makes CBHW support inconsistent, inequitable, and negatively influences the relationships between health staff and CBHWs.

3.4.3. POLICY STATEMENTS

- A standard set of essential medicines and supplies are appropriately provided to all Community Based Health Workers.
- Transportation cost is provided for Community Based Health Workers according to national level governance structure's guidance or instructions, to regularly attend meetings at the local health facility and for local health staff to conduct visits at the community level for purposes of supervision and coordination.
- Standardized financial support is provided according to national level governance structure's guidance or instructions, based on performance and participation in terms of collaboration with local health staff.
- Non-financial incentives are provided, including annual recognition ceremonies and career development opportunities in line with national level governance structure's guidance or instructions.
- Performance is reviewed on a regular basis with positive reinforcement or corrective measures taken accordingly.

- Supportive supervision by local health staff is enabled through allocation of resources, provision of standardized tools and use of information technology.
- Partnership-based supervision approaches are supported by all stakeholders (i.e. MoHS, EHOs, Donors, and partners) with findings compiled and shared to the Township level.

3.4.4. POLICY IMPLEMENTATION APPROACHES

- Standardized supervision tools will be developed and used by local health staff in alignment with the integrated and expanded AMW and CHW roles.
- Realistic frequency expectations and methods for supervision by local health staff will be developed and combined with other outreach activities or quarterly S/RHC meetings where CBHWs provide reports and receive supplies.
- Joint supervision procedures by MoHS, EHOs and all partners will be discussed and defined.
- Standardized set of essential medicines and supplies will be agreed in accordance with the integrated and expanded AMW and CHW roles and provided appropriately to all CBHWs by both MoHS and partners.
- Standardized financial incentives will be provided to all CBHWs according to national level governance structure's guidance or instructions and supported by both MoHS and partners.
- Career development opportunities will be developed and planned for well-functioning and experienced AMWs and CHWs, in conjunction with broader career development planning for Midwives and Public Health Supervisors to support overall health workforce diversification and rural health retention strategies across the country.
- Resource allocation and support for CBHWs will be planned and linked with support for the wider primary healthcare team, so that both CBHWs and local health staff (e.g. Midwives and Public Health Supervisors) are enabled to work together in provision of the basic EPHS to all communities.
- Standardized formats for CBHWs reporting will be developed; existing CBHW reporting formats will be reviewed, combined, simplified, and aligned with the AMW and CHW integrated, expanded service packages.
- Data management system for CBHW reported data will be developed and linked for input to the national Health Management Information System and compatibility with DHIS2.
- Mobile phone technology will be increasingly used to improve regular communication and information sharing between local health staffs and CBHWs (e.g. use of Viber groups and mobile applications to easily report data).
- State/Region, Township and Village/Ward governance structures and mechanisms will be defined with two-way feedback mechanisms and collaboration across each level.
- Terms of Reference and Standard Operating Procedures for the Village/Ward Health Committees will include clear specification for composition, chairing, linkage, coordination and reporting between levels (i.e. Township – Tract – Village/Ward) as an essential channel for enabling two-way feedback mechanism for information sharing and accountability. Responsibilities for coordination with Village/Ward Health Committees will be integrated into local health staff roles.

- National level governance structures and mechanisms will be defined and established with official Terms of Reference for coordination within the MoHS and externally with relevant stakeholders.

4. FINANCING

4.1. VALUE OF COMMUNITY-BASED HEALTH SERVICES

4.1.1. COMMUNITY-BASED SERVICES SAVE LIVES

The global Disease Control Priorities 3rd Edition (DCP3) provides the most up-to-date evidence on intervention efficacy and program effectiveness for the leading causes of global disease burden, including systematic economic evaluation of policy choices affecting the access, uptake, and quality of interventions and delivery platforms for low-and middle-income countries. Analysis of the maternal, newborn and child deaths that could be averted through community, primary health center or hospital platforms showed that 21% of stillbirths, 49% of neonatal deaths, and 93% of child deaths that can be averted by delivering currently available evidence–based interventions through a community platform [3].

4.1.2. COMMUNITY-BASED SERVICES INCREASE ACCESS AND EQUITY

A global review of the inequalities in maternal, newborn, and child health interventions has concluded that community-based interventions are more equitable than static facility-based services alone [15]. The utilization of facility–based services decreases exponentially as the household's distance from the location increases, especially if the facility is greater than 3 km or more than 30 minutes away [16]. In many countries, the mean travel time to the nearest facility is more than 30 minutes and in others considerably more. Construction, staffing, and operating a sufficient number of primary health centers to deliver high–quality care that is readily accessible to the population (within 3 km) and that would be utilized by the majority of the population in order to achieve the same level of coverage of interventions as the community level platform is not achievable in most countries for the foreseeable future. Thus, task shifting to community health workers to provide outreach services in rural communities can help increase overall access to basic interventions [17-18]

4.1.3. COMMUNITY-BASED SERVICES ARE COST EFFECTIVE

Existing evidence suggests that using community health workers to deliver essential health services can be a cost–effective approach for health programs in low-and middle-income countries [19]. Although high–quality community–based programming is not cheap, it is the most effective option to reduce mortality (compared to investing solely in facility–based care), as well as the least expensive option we currently have (compared to investing solely in facility–based care) to end preventable child and maternal deaths in resource–limited countries by 2030 [2, 20]. Achieving the same level of coverage of evidence–based interventions by expanding only facility–based services with more numbers of highly trained personnel will take decades longer and cost much more compared to the expansion of community–based health care through community health workers [21-24].

4.2. GLOBAL EXPERIENCE IN SUSTAINABLE FINANCING

Countries with successful CBHW systems develop sustainable financing solutions, which involve a plan to access revenue from available sources over time even as sources of revenue inevitably change. This is achieved in different ways across country contexts, but usually involves a combination of external donor assistance and domestic resources. In order for CBHWs to be institutionalized within the health system it is imperative for resources to be planned, budgeted, and distributed through mechanisms that are a part of the country's health financing system.

Government funding of CBHW programs is particularly important from a long-term sustainability perspective. While the percentage of support that is provided by governments varies across country examples, the primary domestic sources of financing for CBHW programs are generally national government revenues, sub-national government revenues, borrowing mechanisms, and contributions (including in-kind) from local communities/individuals. When governments fund national CBHW programs, federal funding is often combined with sub-national level funding, including regional/state or municipal funding [25].

In most countries, external donor assistance to support CBHWs will not exist forever and declines quickly in middle-income countries. Therefore, it is important to look at how donor investments in the near-term can be most effectively leveraged to support a sustainable financing strategy in the long-term. One effective strategy some governments have used is to take advantage of disease programs and structure "co-financing deals." Disease-specific funding channels can be leveraged to fund integrated programs at the community level. While there are often donor restrictions on what can be funded within a disease program, funding can also often be combined with other disease-specific channels of funding to support an integrated program. Disease-specific funders are increasingly seeking co-financing arrangements with other donors to increase their value-for-money and to support integrated programming [25].

4.3. SUSTAINABLE FINANCING FOR POLICY IMPLEMENTATION IN MYANMAR

It will be essential to pursue sustainable financing options for implementation of the CBHW Policy in Myanmar, in order to reap the full benefits of the contributions CBHWs can make to delivery of the basic EPHS to the whole population by 2021 and beyond. For CBHWs to be institutionalized within Myanmar's health system, resources will need to be planned, budgeted, and distributed through mechanisms that are a part of the country's health financing system. This will require coordination in planning and budgeting across National, State/Region and Township levels, which can be supported by the Inclusive State/Region and Township Health Planning processes to be introduced across the country under the NHP. It will also be important to leverage current external donor assistance to support transition under the CBHW Policy, including movement toward institutionalization and strengthening of the national health system.

The health financing system of Myanmar includes the three key functions of revenue generation, pooling and purchasing. Primary sources of revenue generation include general revenue (e.g. taxes), external donor assistance and out-of-pocket expenditure.

Government allocations of general revenue to the health sector budget have increased in recent years, but the greatest proportion of overall health spending still comes from out-of-pocket expenditure by people at point of care (i.e. 74% according to the 2015 National Health Accounts). The health financing strategy under the NHP will aim to reduce out-of-pocket expenditure as a part of the effort to extend the basic EPHS to the entire population, while increasing financial protection. This strategy will include how resources will be mobilized to finance progress towards UHC and how risk pooling mechanisms will be developed to help improve affordability of care and address the substantial barriers to seeking care, especially among the poor and vulnerable. It is also likely to involve establishment of a pooling/purchasing entity, which will be responsible for purchasing from different types of providers for delivery of the EPHS, including services delivered in the community.

Inclusive State/Region and Township Health Planning processes will be introduced across the country under the NHP. Planning will be based on a good understanding of current situation: who is doing what and where; which services and interventions reach which communities; where are the gaps and who could fill them. Using this information, stakeholders at Township level, organized in the Township Health Working Group, will be able to jointly plan and cost actions that need to be taken to fill coverage gaps and meet the minimum standards of care. There is a significant opportunity to leverage CBHWs and Village/Ward Health Committees to both inform the development and support the delivery of Inclusive Township Health Plans to deliver the basic EPHS to all communities. As a first step, comprehensive mapping of CBHWs and Village/Ward Health Committees will be needed across all Townships, in order to inform planning and prioritization.

Current external donor assistance for health comes through bilateral, multilateral, and multi-donor consortium channels, including some with significant commitments to support CBHWs over the next three years (2019-2021), such as the ACCESS to Health Fund and The Global Fund. During this timeframe, there is an opportunity to leverage and coordinate external donor assistance to support transition under the CBHW Policy, including movement toward institutionalization and strengthening of the national health system. Similar levels of external donor assistance are not expected to be maintained as Myanmar continues to advance as a middle-income country, so it is essential that current external donor assistance be used effectively now to support the MoHS' long-term vision for service delivery to all communities in the future.

Key steps for supporting implementation of the CBHW Policy and development of a sustainable financing strategy include:

1. Endorsement of the CBHW Policy and political sensitization for support at all levels.
2. Identification of current sources of revenue available, including how to plan for efficient allocation/distribution and complementarity across:
    - MoHS budgets channeled through the National, State/Region and Township levels;
    - Other government budgets at State/Region, Township and below levels;
    - External donor assistance and implementation support from current partners.
3. Development of a transition plan for 2019-2020, which outlines:
    - Immediate priority actions for supporting implementation of the CBHW Policy;
    - Guidance to development partners on how to support transition to institutionalization and implementation of the CBHW Policy

- Calculation of implementation targets and associated costs to inform longer-term planning, including costs for recruitment and initial training; financial and non-financial incentives; equipment, medicines and supplies; management and supervision (e.g. reporting, travel allowance and periodic review); refresher trainings and recurrent meetings.

4. Development of a Five Year Costed Plan for implementation of the CBHW Policy developed to outline how government budgeting, planning and allocation to CBHWs will work moving forward as well as how sustainable funding sources will be accessed and strategically allocated to support implementation of the CBHW Policy. This could include identification of possible new sources of revenue and innovative financing mechanisms including:
    - Global Financing Facility;
    - Co-financing deals and arrangements for pooling of future donor investments;
    - Strategic purchasing through a pooling/purchasing entity in the country

5. MONITORING AND EVALUATION

Monitoring and evaluation will be essential for guiding implementation, measuring progress, and holding all stakeholders accountable to supporting the CBHW Policy, including transition to institutionalization and strengthening of national health systems to the community level. The MoHS (specific focals) will monitor policy implementation, including to what extent the policy is being linked to and reflected in national strategic plans, Inclusive State/Region/Township Health Plans and development partner supported programs.

The Monitoring and Evaluation Framework will include key monitoring and evaluation indicators across each of the four prioritized areas of the CBHW Policy. It will include indicator linkages with the NHP M&E Plan, Human Resources for Health Strategic Plan M&E Framework, and other relevant plans. Data will be drawn from existing data sources and the standardized CBHW reporting, supervision, and performance management systems to be established under the CBHW Policy for integration to the national HMIS and HRMS.

6. GOVERNANCE

6.1. GLOBAL GUIDANCE ON GOVERNANCE ARRANGEMENTS

Improving how CBHW programs, and health systems more broadly, are governed is increasingly recognized as important in achieving universal access to health care and other health-related goals. Governing comprises the processes and structures through which individuals and groups exercise rights, resolve differences, and express interests. The process of governing involves ongoing interactions among actors, such as health care decision makers, community representatives, and agencies, and structures, including the laws, resources, and beliefs within which these actors operate. Community-Based Health Workers programs are usually located between the formal health system and communities and involve a wide range of stakeholders at local, national, and international levels, so their governance is often complex and relational [2]. Adequate governance arrangements to support successful implementation of a national CBHW policy will need to consider processes and structures for bringing together the necessary range of stakeholders; achieving and maintaining political support at all levels; developing and passing supportive laws and regulations; adapting across different settings or groups within the country.

6.2. GOVERNANCE ARRANGEMENTS IN MYANMAR

In Myanmar, the realization of the CBHW Policy will require effective governance and coordination across actors within and outside the MoHS, including the following:

Ministry of Health and Sports:

- Department of Public Health
- Department of Medical Services
- Department of Human Resources for Health
- Department of Medical Research
- Department of Food and Drug Administration

Other Ministries and Institutions:

- Parliaments
- Ministry of Planning, Finance, and Industry
- Ministry of Investment and Foreign Economic Relations
- Ministry of Social Welfare, Relief and Resettlement
- Ministry of Labour, Immigration and Population
- Ministry of Office of the Union Government

Partners:

- United Nations Agencies
- Donors
- Civil Society Organizations
- Myanmar Red Cross Society
- Ethnic Health Organizations
- International Non-Government Organizations
- Non-Governmental Organizations
- Private Sector

The BHS Section within the MoHS Department of Public Health will be the focal point for implementation of the CBHW Policy within the MoHS. The CBHW Core Group will guide and take decisions and the CBHW Working Group will be expanded (becoming a Technical Working Group or Technical Strategy Group) to include Development Partners, in order to support planning, coordination and implementation under the national CBHW Policy.

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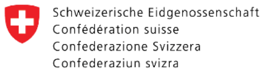
ACCESS TO HEALTH FUND



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