

**Female community health volunteers to reduce blood pressure
feasible and sustainable? – Authors' reply**

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Female community health volunteers to reduce blood pressure: feasible and sustainable?

Authors' reply

We thank K C Bhuvan and Saval Khanal for their Correspondence regarding our Article.¹ Their letter addresses important issues regarding the feasibility and sustainability of Nepal's female community health volunteer (FCHV) programme.

Historically speaking, research on the effectiveness of community-based approaches to improve the health of mothers and children has often begun with a similar approach—ie, the implementation of interventions in settings in which the conditions are ideal, with assurance that those implementing the intervention are well trained, appropriately supervised, and have the necessary logistical support they need to carry out the intervention.² Once this proof of concept has been established, with additional research, the task then becomes whether and how to apply the intervention on a broader scale under more routine conditions.

Nepal is undergoing an epidemiological transition, with a growing burden of non-communicable diseases (NCDs). The changes in the burden of diseases should be matched by changes in the roles of FCHVs. We also previously showed that FCHVs are willing to take on additional responsibilities, such as blood pressure screening and personalised counselling at the community level.^{3,4} According to the national survey report on FCHVs, FCHVs spent 7.2 h per week doing health-related volunteer work.

We are aware of the issues related to compensation for FCHVs, but the FCHVs (by national policy) are still a volunteer group and they have a choice about which activities they do and how much time they are willing

to devote. The decision to not provide direct monetary benefit to FCHVs is in line with government policy and the country's financial capacity to sustain it.³ If the community values the FCHVs' services, they are more likely to consult with an FCHV and visit FCHVs at their homes to minimise their workload.

Community engagement with FCHVs has a direct benefit to the FCHV, in that it will elevate the social standing of her and her family, irrespective of monetary benefits.⁵ We also found that 99% of FCHVs indicated that they were willing to contribute to community education and screening programmes for hypertension without receiving any financial or other incentives.³

Our study is a proof of concept in a low-income setting, showing that FCHVs are effective for blood pressure screening and promoting health counselling.¹ We are in favour of the addition of blood pressure screening through the involvement of primary health-care outreach clinics, Expanded Program on Immunisation clinics, grass-roots-level health facilities, and pharmacists. However, these activities should not preclude FCHV engagement in hypertension programming because, first, FCHVs will be much more effective in reaching the entire population than will providers based at facilities and, second, providers at facilities are constrained by fixed days and hours of operation and location, thereby limiting the availability of screening and counselling in ways that FCHVs can overcome through their outreach to all households at times that are convenient for those in the household. Because of challenging topography, financial constraints, scattered settlements, and limited supply of professional health workers, it is unlikely that everyone will have an equal opportunity to receive these services unless FCHVs provide them. We believe that, given the strength and nature of their local community-based knowledge and relationships,

FCHVs form an ideal platform for the management and prevention of NCDs such as cardiovascular disease as part of an integrated health service in Nepal.

We declare no competing interests.

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