



HIFA discussion on CHWs Discussion 2: Oct-Nov2019

Appropriate supervision,
remuneration, career ladder
and workload

LONG EDIT

<http://www.hifa.org/news/hifa-thematic-discussion-community-health-workers-part-2-appropriate-supervision-remuneration>

HIFA continues our collaboration with WHO, Health Systems Global (CHW Thematic Working Group) and other key organisations (icddr,b) on a series of three major HIFA thematic discussions on CHWs. These discussions are supporting the dissemination and uptake of the WHO Guideline on health policy and system support to optimize community health worker programmes (CHW Guideline), launched in October 2018.

The first thematic discussion took place in June and July 2019 and looked at selection, training and certification of CHWs. More information and summaries are available [here](#).

Our second thematic discussion started on 21 October 2019 and ran for 4 weeks.

The work is led by the [HIFA working group on Community Health Workers](#).

The following questions were offered as a framework for discussion. Note that we encouraged contributions on *any* aspect of CHWs at *any* time for the duration of this project (ends Sept 2020).

Q1. Recommendation 6 suggests certain strategies (appropriate supervisor–supervisee ratio allowing meaningful and regular support; ensuring supervisors receive adequate training; coaching and mentoring of CHWs; use of observation of service delivery, performance data and community feedback; prioritization of improving the quality of supervision) to use for **supportive supervision** of CHWs. How do these relate to current practice in your country/experience? Are they implementable in your country/experience?

Q2. Recommendation 7 recommends **remuneration** of CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake. WHO suggests not paying CHWs exclusively or

predominantly according to performance-based incentives. How does this relate to current practice in your country/experience? Is it implementable in your country/experience?

Q3. **Recommendation 8** recommends providing paid CHWs with a written agreement specifying **role and responsibilities**, working conditions, remuneration and workers' rights. How does this relate to current practice in your country/experience? Is it implementable in your country/experience?

Q4. **Recommendation 9** suggests that a **career ladder** should be offered to practising CHWs, recognizing that further education and career development are linked to selection criteria, duration and contents of pre-service education, competency-based certification, duration of service and performance review. How does this relate to current practice in your country/experience? Is it implementable in your country/experience?

Q5. **Recommendation 10** suggests using the following criteria in most settings to determine a **target population size** in the context of CHW programmes: expected workload based on epidemiology and anticipated demand for services; frequency of contact required; nature and time requirements of the services provided; expected weekly time commitment of CHWs (factoring in time away from service provision for training, administrative duties, and other requirements); local geography (including proximity of households, distance to clinic and population density). How feasible is it in your country/context to determine CHW:population ratios taking these factors into consideration? If your country/programme currently does this, what tools do you use?

The WHO Guideline: Health policy and system support to optimize community based health worker programmes is available here:

<https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1>

1. Recommendation 6: Supportive supervision

1.1 What the Guideline says

Recommendation 6 suggests certain strategies to use for supportive supervision of CHWs:

1. appropriate supervisor-supervisee ratio allowing meaningful and regular support;
2. ensuring supervisors receive adequate training;
3. coaching and mentoring of CHWs;
4. use of observation of service delivery, performance data and community feedback;
5. prioritization of improving the quality of supervision.

'The importance of adequate supervision of CHWs is well recognized. International evidence suggests that regular and systematic supervision, with clearly defined objectives, can improve the performance of CHWs involved in primary health care (100102). Supportive supervision that targets and measures knowledge and skills, motivation, and adherence to correct practices provides incentives that positively impact performance (103). There is also emerging evidence suggesting that employing mobile phones, including for better supervision, can improve health care delivery in resource-limited settings (104).

'A typical challenge however is a lack of resources to provide a supportive supervision and environment to optimize the capacity of CHWs (21, 105, 106). It is essential to streamline the

supervision process by identifying effective strategies and including them in the implementation of interventions.

'The evidence retrieved and analysed for the purpose of this guideline reiterated the importance of supportive supervision and identified a number of supervision strategies in the context of different programmes and initiatives. However, the studies typically did not compare specific supervision strategies against others in terms of effectiveness, costs, acceptability, feasibility or other outcomes.'

'In light of the very low certainty of the evidence and the need to adapt supervisory strategies to the requirements of different contexts, this recommendation was a conditional one.'

1.1.1 Summary of evidence

'The systematic review (Annex 6.6) on the question "In the context of community health worker programmes, what strategies of supportive supervision should be adopted over what other strategies?" (107) identified 13 eligible studies: nine quantitative, of which five were RCTs, and four qualitative.

'The studies came from India (three studies), Ethiopia, Kenya, and Uganda (two studies each), and Lao People's Democratic Republic, Malawi, Pakistan, and the United Republic of Tanzania (one study each). Various approaches and modalities of supervision were found to be effective in improving various aspects of CHW programme performance (108114), in some cases also showing a dose gradient response (115), while on limited occasions there was no measurable difference on some outcomes between the study arm receiving the supervision intervention and the study arm that did not (116, 117). The qualitative studies found evidence that different supportive supervision strategies were deemed helpful and reinforced motivation by the CHWs themselves (116, 118120).'

'Thee systematic review of reviews found several studies confirming the critical importance of supportive supervision to enhance CHW quality, motivation and performance (13, 51, 121-125). However, it similarly found very limited evidence on which supervisory approaches work best. Supervision that focuses on supportive approaches, quality assurance and problem solving may be most effective at improving CHW performance (as opposed to more bureaucratic and punitive approaches) (17, 105, 126).'

'The systematic review (Annex 6.6) on the question "In the context of community health worker programmes, what strategies of supportive supervision should be adopted over what other strategies?" (107) identified 13 eligible studies: nine quantitative, of which five were RCTs, and four qualitative. The studies came from India (three studies), Ethiopia, Kenya, and Uganda (two studies each), and Lao People's Democratic Republic, Malawi, Pakistan, and the United Republic of Tanzania (one study each).'

I was unable to find Annex 6, but the Guideline notes that 'The systematic review of reviews found several studies confirming the critical importance of supportive supervision to enhance CHW quality, motivation and performance (13, 51, 121125). However, it similarly found very limited evidence on which supervisory approaches work best.'

The citation and abstract of one of these studies is shown below.

CITATION: Glob Health Action. 2014 May 8;7:24085. doi: 10.3402/gha.v7.24085. eCollection 2014.

Supervising community health workers in low-income countries--a review of impact and implementation issues.

Hill Z1, Dumbaugh M2, Benton L2, Kollander K3, Strachan D2, ten Asbroek A4, Tibenderana J3, Kirkwood B4, Meek S3.

ABSTRACT

BACKGROUND: Community health workers (CHWs) are an increasingly important component of health systems and programs. Despite the recognized role of supervision in ensuring CHWs are effective, supervision is often weak and under-supported. Little is known about what constitutes adequate supervision and how different supervision strategies influence performance, motivation, and retention.

OBJECTIVE: To determine the impact of supervision strategies used in low- and middle-income countries and discuss implementation and feasibility issues with a focus on CHWs.

DESIGN: A search of peer-reviewed, English language articles evaluating health provider supervision strategies was conducted through November 2013. Included articles evaluated the impact of supervision in low- or middle-income countries using a controlled, pre-/post- or observational design. Implementation and feasibility literature included both peer-reviewed and gray literature.

RESULTS: A total of 22 impact papers were identified. Papers were from a range of low- and middle-income countries addressing the supervision of a variety of health care providers. We classified interventions as testing supervision frequency, the supportive/facilitative supervision package, supervision mode (peer, group, and community), tools (self-assessment and checklists), focus (quality assurance/problem solving), and training. Outcomes included coverage, performance, and perception of quality but were not uniform across studies. Evidence suggests that improving supervision quality has a greater impact than increasing frequency of supervision alone. Supportive supervision packages, community monitoring, and quality improvement/problem-solving approaches show the most promise; however, evaluation of all strategies was weak.

CONCLUSION: Few supervision strategies have been rigorously tested and data on CHW supervision is particularly sparse. This review highlights the diversity of supervision approaches that policy makers have to choose from and, while choices should be context specific, our findings suggest that high-quality supervision that focuses on supportive approaches, community monitoring, and/or quality assurance/problem solving may be most effective.

Moderator: I would like to share with you the list of research papers on this topic, which the WHO CHW Guideline Group identified to create Recommendation 6.

1. Chang LW, Kagaayi J, Arem H, Nakigozi G, Ssempijja V, Serwadda D et al. Impact of a mHealth intervention for peer health workers on AIDS care in rural Uganda: a mixed methods evaluation of a cluster-randomized trial. *AIDS and Behavior*. 2011;15(8):1776844.
2. Das A, Friedman J, Kandpal E, Ramana GN, Gupta RK, Pradhan MM et al. Strengthening malaria service delivery through supportive supervision and community

mobilization in an endemic Indian setting: an evaluation of nested delivery models. *Malaria Journal*. 2014;13:482.

3. Singh D, Negin J, Orach CG, Cumming R. Supportive supervision for volunteers to deliver reproductive health education: a cluster randomized trial. *Reproductive Health*. 2016;13(1):126.
4. Som M, Panda B, Pati S, Nallala S, Anasuya A, Chauhan AS et al. Effect of supportive supervision on routine immunization service delivery: a randomized post-test study in Odisha. *Global Journal of Health Science*. 2014;6(6):617.
5. AAyele F, Desta A, Larson C. The functional status of community health agents: a trial of refresher courses and regular supervision. *Health Policy and Planning*. 1993;8(4):379-84.
6. Kaphle S, Matheke-Fischer M, Lesh NN. Effect of performance feedback on community health workers motivation and performance in Madhya Pradesh, India: a randomized controlled trial. *JMIR Public Health and Surveillance*. 2016;2(2):e169.
7. DeRenzi B, Findlater L, Payne J, Birnbaum B, Mangilima J, Parikh T et al. Improving community health worker performance through automated SMS. 2012.
8. Ameha A, Karim AM, Erbo A, Ashenafi A, Hailu M, Hailu B et al. Effectiveness of supportive supervision on the consistency of integrated community cases management skills of the health extension workers in 113 districts of Ethiopia. *Ethiopian Medical Journal*. 2014;52(Suppl. 3):6571.
9. Nonaka D., Pongvongsa T, Nishimoto F, Nansounthavong P, Hongwei J, Vongsouvanh A et al. Successful mobile phone network-based approach to integration of the health care system in rural Laos: strengthening lay health worker performance. *Rural and Remote Health*. 2014;14:2588.
10. Rowe SY, Kelly JM, Olewe MA, Kleinbaum DG, McGowan JE Jr, McFarland DA et al. Effect of multiple interventions on community health workers' adherence to clinical guidelines in Siaya district, Kenya. *Transactions of the Royal Society of Tropical Medicine and Hygiene*. 2007;101(2):188202.
11. Henry JV, Winters N, Lakati A, Oliver M, Geniets A, Mbae SM et al. Enhancing the supervision of community health workers with WhatsApp mobile messaging: qualitative findings from 2 low-resource settings in Kenya. *Global Health Science and Practice*. 2016;4(2):31125.
12. Rabbani F, Perveen S, Aftab W, Zahidie A, Sangrasi K, Qazi SA. Health workers' perspectives, knowledge and skills regarding community case management of childhood diarrhoea and pneumonia: a qualitative inquiry for an implementation research project "Nigraan" in district Badin, Sindh, Pakistan. *BMC Health Services Research*. 2016;16:462.
13. Callaghan-Koru JA, Hyder AA, George A, Gilroy KE, Nsona H, Mtimuni A et al. Health workers' and managers' perceptions of the integrated community case management

program for childhood illness in Malawi: the importance of expanding access to child health services. *American Journal of Tropical Medicine and Hygiene*. 2012;87(Suppl. 5):618.

Below is one of the 13 papers that helped to inform Recommendation 6 of the WHO CHW Guideline. I have selected this specifically, partly because it is recent (2016) and also because the study design is - unusually - a randomized controlled trial. I have invited the authors to join us and comment and meanwhile look forward to learn from your experience.

CITATION: *JMIR Public Health Surveill*. 2016 Dec 7;2(2):e169.

Effect of Performance Feedback on Community Health Workers' Motivation and Performance in Madhya Pradesh, India: A Randomized Controlled Trial.

Kaphle S1, Matheke-Fischer M2, Lesh N1.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5177738/>

Abstract

BACKGROUND: Small-scale community health worker (CHW) programs provide basic health services and strengthen health systems in resource-poor settings. This paper focuses on improving CHW performance by providing individual feedback to CHWs working with an mHealth program to address malnutrition in children younger than 5 years.

OBJECTIVE: The paper aims to evaluate the immediate and retention effects of providing performance feedback and supportive supervision on CHW motivation and performance for CHWs working with an mHealth platform to reduce malnutrition in five districts of Madhya Pradesh, India. We expected a positive impact on CHW performance for the indicator they received feedback on. Performance on indicators the CHW did not receive feedback on was not expected to change.

METHODS: In a randomized controlled trial, 60 CHWs were randomized into three treatment groups based on overall baseline performance ranks to achieve balanced treatment groups. Data for each treatment indicator were analyzed with the other two treatments acting as the control. In total, 10 CHWs were lost to follow-up. There were three performance indicators: case activity, form submissions, and duration of counseling. Each group received weekly calls to provide performance targets and discuss their performance on the specific indicator they were allocated to as well as any challenges or technical issues faced during the week for a 6-week period. Data were collected for a further 4 weeks to assess intertemporal sustained effects of the intervention.

RESULTS: We found positive and significant impacts on duration of counseling, whereas case activity and number of form submissions did not show significant improvements as a result of the intervention. We found a moderate to large effect (Glass's delta=0.97, P=.004) of providing performance feedback on counseling times in the initial 6 weeks. These effects were sustained in the postintervention period (Glass's delta=1.69, P<.001). The counseling times decreased slightly from the intervention to postintervention period by 2.14 minutes (P=.01). Case activity improved for all CHWs after the intervention. We also performed the analysis by replacing the CHWs lost to follow-up with those in their treatment groups with the closest ranks in baseline performance and found similar results.

CONCLUSIONS: Calls providing performance feedback are effective in improving CHW motivation and performance. Providing feedback had a positive effect on performance in the case of duration of counseling. The results suggest that difficulty in achieving the

performance target can affect results of performance feedback. Regardless of the performance information disclosed, calls can improve performance due to elements of supportive supervision included in the calls encouraging CHW motivation.

1.2 Definition of supportive supervision

The term 'supportive supervision' is not further defined per se, but 'The stakeholder perception survey identified most supportive supervision strategies (including coaching, observation at community and facility, community feedback, and supervision by trained health workers) to be acceptable and feasible, but lower levels of acceptability and especially of feasibility were identified for direct supervision of service delivery and supervision conducted by other CHWs'.

1.3 Unsupportive supervision

(From Discussion 1): Flata Mwale, Zambia: "The lack of any document to protect [CHW] interests especially those in rural areas where supervision and monitoring of responsible cadres are still inadequate and have placed CHWs literally at the mercy of their immediate supervisors. The work they are doing in contributing to achieving global public health deserves recognition.'

Neil: The image of CHWs being "at the mercy of their immediate supervisors" indicates that sometimes supervision can be anything *but* supportive. I am reminded when I was at a faith-based hospital in India, I observed a rigid hierarchy whereby nurses were subordinated to doctors and were fearful to ask questions. The same was true of pharmacists ("I would never question a doctor, even if I knew they had prescribed the wrong dose"). How widespread are such dysfunctional hierarchies? Do they prevail among primary healthcare workers also?

1.4 Supervision of CHWs delivering FP services

Maryse Kok (Netherlands): I would like to add a note on the role of CHWs in providing contraceptive services. Recently, Amref Health Africa and the KIT Royal Tropical Institute conducted a study on the role of Health Surveillance Assistants (HSAs) in the provision of contraceptive services in Malawi. We concluded that HSAs are trusted providers of short term contraceptives, but that their ability to include male and youth in their health promotion activities and to address (the many!) misconceptions around contraceptives needs improvement.

Maryse Kok (Netherlands): HSAs are primarily supervised by officers from the environmental health department. However, contraceptive services fall under the family planning department in Malawi. There seemed to be a disconnect between the two departments, and as a result the supervision of HSAs on the provision of contraceptive services was minimal.

Maryse Kok (Netherlands): This might happen in other settings as well: CHWs with a broad task description are supposed to be supervised by different people for different tasks, which can bring in challenges. Any experiences from other countries, or good examples of integrated supervision?

Maryse Kok (Netherlands): Our study from Malawi will be presented at the upcoming CHW conference in Dhaka. Hope to see some of you there!

Andre Shongo Diamba (DR Congo): In the DRC, there are several groups that play interface role community health facilities in what we call Community Health System. Social Mobilizers (Mobilisateurs Sociaux), Community Relays (Relais Communautaires), Community Based Distributors (Distributeurs a base communautaire) and other, possess different backgrounds, but trained in contraception and Family planning (sensitization, social marketing, administration of no clinic methods). CHWs supervisors come either from Health Zone (public sector) or from specific organization (private sector).

Andre Shongo Diamba (DR Congo): CHWs provide the community method (non-clinic methods): calendar, lactational amenorrhea method, standard day's method, pills and SAYANA press. Supervision key stages are preparedness, in ground deployment, days closure meeting (data collection, evaluation, recommendation and tomorrow schedule). CHWs provide free contraception / Family Planning in community scale (community distribution campaign), door to door in areas targeted. Most time a fixed site, health facility is chosen to serves as referral point for all methods, clinic and no clinic. CHWs have diversified background, medical and no medical, youth and adult, male and female.

Andre Shongo Diamba (DR Congo): PHOrg is following the debate about CHWs accreditation and propose to pledge near decision makers to adopt the concept CHWs and involve them in Community Health System, current vision that can help to achieve the Primary Health Care and apply to Universal Health Coverage.

Sanchika Gupta (India): Accredited Social Health Activists (ASHA) is an incentive worker by health department in the village, catering a population of 1000 approximately. Health ministry of India has issued a refresher booklet on update of new contraceptive methods for ASHA. This has an overview of different schemes for ASHA.

https://humdo.nhp.gov.in/wp-content/uploads/2017/07/Asha_Booklet_2017.pdf

Alison Nicholls (UK)): Whilst it is excellent that women are being offered contraceptive choices by CHWs, calendar or rhythm methods are not taught in the UK by NHS contraceptive service providers because of their high failure rate. Does the DR Congo have any data about the reliability of these methods? It is good that the much more reliable progesterone only self administered hormone injection SAYANA press is being taught as an alternative to the combined pill which requires greater assessment, education and monitoring of the women for it to be used safely.

Andre Shongo Diamba (DR Congo): (to Alison Nicholls) In the DRC, Family Planning training curriculum teaches about traditional versus modern methods, and ranks the last one about natural (calendar /rhythm method, standard days methods and Lactational amenorrhea method) versus artificial that include barriers methods (condom, IUD, spermicide), hormonal methods (progestin only progesterone, Combined Oral contraceptive, injectable depo Provera, SAYANA press, and Noristerat, implant jadelle and Implanon NXT), and surgical methods; male and female sterilization.

Andre Shongo Diamba (DR Congo): (to Alison Nicholls) I have some answers to your questions below :

1. "Whilst it is excellent that women are being offered contraceptive choices by CHWs, calendar or rhythm methods are not taught in the UK by NHS contraceptive service providers

because of their high failure rate. Does the DR Congo have any data about the reliability of these methods?"

Majority of people are Christian, and among them there are those who like to use exclusively natural methods, especially calendar. CONDUITE DE FECONDITY (Fertility leading) a catholic church works in this principle. Unfortunately, there is not national using rate but one study led in capital city Kinshasa had found the high use of calendar/ standard days' method, <https://www.pma2020.org/sites/default/files/PMA2020%20Round%201%20Final%20report%20Oct%2025%202014.pdf>

In practice, the lactational amenorrhea method and Standard Days' work well and are reliable once used. As you, Modern Family Planning Methods providing are based in voluntary principle and informed choice, many clients choose them.

2. "Does the self-administered hormone injection SAYANA press is being taught as an alternative to the combined pill?"

You are right about self-subcutaneous SAYANA Press that benefits advantages of intramuscular Depo Provera of being reliable, administered in confidentiality and popular. SAYANA press is progressing, and in a certain measure will be used as preferred contraceptive containing only progesterone. Other side, SAYANA press don't contains estradiol combined with progesterone in combined pill, in this point of view, we think that SAYANA press and Combined pill are different, they need to be proposed separately in the modern contraceptive methods wide game.

1.5 Practical Approach to Care Kit

Joseph Ana (Nigeria): Having been following the interesting contributions to this discussion, I am drawn to post our recent experience about the use of supportive supervision in Nigeria PHC. To illustrate the point, the utility of supportive supervision of CHW, I shall quote extensively from the publication on the PACK Nigeria for PHC pilot in 2017, below:

Joseph Ana (Nigeria): 'In 2014, a task-shifting policy⁸ was developed that promotes redistribution of tasks between the different categories of PHC clinician: doctors, nurses, midwives, community health officers (CHOs), community health extension workers (CHEWs) and junior community health extension workers (JCHEWs). Although this policy has achieved some successes, for example, improvement of access to long-acting reversible contraception,⁹ improved knowledge on the management of stroke¹⁰ and access to mental health services¹¹ in some regions of the country, there is little evidence of a general improvement in the delivery of comprehensive PHC.

Joseph Ana (Nigeria): In order to address this skills deficit, the British Medical Journal (BMJ) proposed to introduce the Practical Approach to Care Kit or PACK programme. The PACK programme is a health systems intervention that supports streamlined delivery of primary care by frontline clinicians in low-resource settings. It has four components: a clinical guide for point of care use, an in-service training strategy, a health systems strengthening component (facility readiness) and monitoring and evaluation, including supportive supervision. The programme was developed by the Knowledge Translation Unit in Cape Town, South Africa, through a process of formative research spanning 18 years, and has been scaled up in primary care facilities throughout South Africa by the National Department of Health. The PACK guide is evidence-aligned, updated annually and focuses

on poorly resourced health systems. A global version of the PACK Adult guide has been developed and has also been successfully localised for and implemented in other low-middle income countries. The process of localisation, conducted in Nigeria by Health Resources International West Africa (HRIWA) involves more than adaptation, as it may involve creation of new context-specific content to accommodate the disease profile, national treatment policies and guidelines, essential drug lists and staff composition of the host country. Pragmatic clinical trials and qualitative research studies have confirmed the positive impact of introducing PACK programme on quality of adult PHC and staff satisfaction. The logic model for PACK is that providing clear actionable point of care clinical guidance to the whole clinical team, that is, all cadres of clinician, accompanied by a customised continuous programme of case-based on-site in-service training and supportive supervision, improves clinical competence, encourages teamwork and task-sharing and effects health system change through prompting standardisation of care, including the supply of essential equipment, medicines and tests, and pathways for referral.

Joseph Ana (Nigeria): The initiative to pilot PACK in Nigeria was sponsored by the National Primary Health Care Development Agency (NPHCDA), and three states in Nigeria, Adamawa, Nasarawa and Ondo, supported by Oxford Policy Management and implemented by Health Resources International West Africa (HRIWA) in partnership with the Knowledge Translation Unit of the University of Cape Town Lung Institute (KTU) and BMJ and carried out within the framework of the World Bank-assisted performance-based financing initiative. This paper describes the localisation of the PACK programme for Nigeria by HRIWA with mentorship from the KTU, its pilot implementation in three states and lessons learnt from this experience.

Joseph Ana (Nigeria): A critical element that sustains the PACK programme is the provision of ongoing supportive supervision to PACK trainers and clinicians. In Nigeria, some of this support was delivered via social media, an approach that has been successful elsewhere. Four WhatsApp groups were created: three for the state-level facility trainer groups and one for the master trainers. Over 6 months, 2236 messages were shared, providing support for facilities and trainers, scheduling administrative meetings, announcements, supervisory messages, feedback on guide use and sharing stories of successful patient care using PACK Nigeria. Quarterly action plans, records of training and photographs and videos of training sessions were also shared.

FULL TEXT:

Using a mentorship model to localise the Practical Approach to Care Kit (PACK): from South Africa to Nigeria. *BMJ Global Health* Oct 2018, 3 (Suppl 5) e001079; DOI: 10.1136/bmjgh-2018-001079 https://gh.bmj.com/content/3/Suppl_5/e001079

1.6 Helping Health Workers Learn and other practical manuals to support CHWs

Moderator: In a previous message, I suggested 'there needs to be a practical manual (or indeed series of manuals) to guide CHW program managers, linking with and referring to the Guideline. We mentioned earlier the Hesperian publication Helping Health Learners Learn.'

Moderator: The Hesperian website sells the latest 2012 edition of Helping Health Workers Learn [https://store.hesperian.org/prod/Helping_Health_Workers_Learn.html] but I could not find a free PDF version (although Hesperian does provide other PDFs free of charge, including Where There is No Doctor).

Moderator: Helping Health Workers Learn: A book of methods, aids, and ideas for instructors at the village level
David Werner and Bill Bower

Moderator: The previous version (2005) is freely available here:
<https://ecta-international.org/files/200000162-70c8771c38/Helping%20Health%20Workers%20Full%20Book.pdf>

Moderator: A testimonial for Helping Health Workers Learn states: "The 'health workers' of the title are not doctors and nurses, but village health workers - laypeople with a special interest in and calling for working with health problems, laypeople who are natural helpers. But there is much in this volume for professional health workers to learn. Helping Health Workers Learn is one of the few books on health education that face up to this major problem: many health education programs increase layfolks' dependence on all-powerful professionals and undermine people's sense of their own abilities to take care of themselves. The authors clearly recognize that one of the biggest obstacles to self-responsibility in health is the unwillingness of professionals to let go of control."

Tom Ferguson, MD, Self Care Archives

Moderator: What other guides do you know of and how might they be enhanced by the new Guideline?

David Werner: I am glad to see your mention of "Helping Health Workers Learn" (a companion handbook to "Where There Is No Doctor") by Bill Bower and myself, in your discussion of the empowerment of CHWs. The book is in fact freely available online, in PDF format, from Hesperian Health Guides. To find it, open <https://hesperian.org/books-and-resources/>. Then go down the list of books to "Helping Health Workers Learn" and click on DOWNLOAD PDF. The whole book can be downloaded (chapter by chapter) free of charge. From that, it can be reassembled, printed, and distributed, however widely, provided this is done on a non-profit basis.

It has always been the intent of the authors and original contributors of this book that it be made available through an open copyright policy, for the common good. The authors receive no royalties or profit from its distribution.

In terms of the empowerment (versus disempowerment) of CHWs, readers may find eye-opening my old (1977) but still pertinent article, "The village health worker, lackey or liberator" --

http://healthwrights.org/content/articles/lackey_or_liberator.htm

Todd Jailer, USA: Hesperian's reason for existing is to produce resources for Community Health Workers, and our practice is always to make them digitally available free of charge in as many languages as possible. It is unfortunate that many in HIFA seem to only pay attention to the earliest books - perhaps a reflection of their age and how long it has been since they were community health workers!

Todd Jailer, USA: In the HIFA postings on CHWs of November 8, a number of topics were raised, and Hesperian has materials in many languages freely available online that address all of them (not just Helping Health Workers Learn). For example:

Todd Jailer, USA: First Aid in English, Spanish, Haitian Kreyol, and Portuguese.

<https://en.hesperian.org/hhg/New Where There Is No Doctor:Chapter 3: First Aid>

Newborn Care in Arabic, English, Spanish, Filipino, French, Hausa, Haitian Kreyol, Somaaliga, Portuguese, Swahili, Chinese, Lao, Khmer, Urdu, Amharic, and Nepali.

<https://en.hesperian.org/hhg/New Where There Is No Doctor:Chapter 27: Newborn Babies and Breastfeeding>

Diabetes in English, Bangla, Spanish, Haitian Kreyol, Khmer, Swahili, Nepali, Chinese and Lao.

<https://en.hesperian.org/hhg/New Where There Is No Doctor:Chapter 21: Diabetes>

Todd Jailer, USA: I'd also like to point out that just as Helping Health Workers Learn is a companion to Where There Is No Doctor, we also have a great manual called Health Actions for Women which is a companion to Where Women Have No Doctor. Versions of all the above are also freely available online on our website.

Todd Jailer, USA: Please don't use versions posted on other websites. They are not guaranteed to be corrected and updated as materials are directly from Hesperian. Community Health Workers deserve accurate, timely information - and unlike other online enthusiasts, Hesperian actually provides it.

Moderator: Thank you [David Werner] for your message about your book "Helping Health Workers Learn", pointing out that it is indeed freely available for download from Hesperian Health Guides [<http://www.hifa.org/dgroups-rss/chws-41-practical-manuals-how-empower-chws-3-helping-health-workers-learn-2>].

Moderator: This kind of format (simple, plain text with pictures and explanations) seems especially useful as a practical guide in 'Helping *Community* Health Workers Learn'. Indeed, CHWs is the prime focus of the book, even though the term itself is only mentioned once or twice.

Moderator: Looking at the title pages of the publication, it appears to still be in its 1st Edition (1982) and on its 14th printing. Both these points would suggest its veracity, popularity and continued relevance and usefulness.

Moderator: Our collective challenge is to understand better *how* to empower CHWs and to provide the best resources to do so. How do we proceed? We can disseminate and encourage uptake of the CHW Guideline. But I suspect this is not enough. We also need to facilitate the development of new practical resources for CHWs and managers that are presented in the most useful format while being reflective of latest research and experience. To start, perhaps we need to identify the 'most important' (however we define the term) manuals of this kind that already exist and see how they can be further enhanced. Such enhancement might be through integration of the latest findings of the WHO Guideline on CHWs; through sharing of experience across different CHW programmes in different countries; and/or through learning from pedagogy and - especially - from the new opportunities provided by digital health.

1.7 ExPRESS

Michael Schriver, Denmark: Concerning publications on supportive supervision of CHWs, one problem may be to evaluate whether supervision is in fact supportive. The paper below documents the development and validation of a tool with which primary health care providers (which might include CHWs) can evaluate if their external supervision is supportive:

Schriver M, Cubaka VK, Vedsted P, Besigye I, Kallestrup P. Development and validation of the ExPRESS instrument for primary health care providers' evaluation of external supervision. *Glob Health Action*. 2018;11(1):1445466.
doi: 10.1080/16549716.2018.1445466. PubMed PMID: 29547066; PubMed Central PMCID: PMC5945230.

Abstract

BACKGROUND: External supervision of primary health care facilities to monitor and improve services is common in low-income countries. Currently there are no tools to measure the quality of support in external supervision in these countries.

AIM: To develop a provider-reported instrument to assess the support delivered through external supervision in Rwanda and other countries.

METHODS: "External supervision: Provider Evaluation of Supervisor Support" (ExPRESS) was developed in 18 steps, primarily in Rwanda. Content validity was optimised using systematic search for related instruments, interviews, translations, and relevance assessments by international supervision experts as well as local experts in Nigeria, Kenya, Uganda and Rwanda. Construct validity and reliability were examined in two separate field tests, the first using exploratory factor analysis and a test-retest design, the second for confirmatory factor analysis.

RESULTS: We included 16 items in section A ('The most recent experience with an external supervisor'), and 13 items in section B ('The overall experience with external supervisors'). Item-content validity index was acceptable. In field test I, test-retest had acceptable kappa values and exploratory factor analysis suggested relevant factors in sections A and B used for model hypotheses. In field test II, models were tested by confirmatory factor analysis fitting a 4-factor model for section A, and a 3-factor model for section B.

CONCLUSIONS: ExPRESS is a promising tool for evaluation of the quality of support of primary health care providers in external supervision of primary health care facilities in resource-constrained settings. ExPRESS may be used as specific feedback to external supervisors to help identify and address gaps in the supervision they provide. Further studies should determine optimal interpretation of scores and the number of respondents needed per supervisor to obtain precise results, as well as test the functionality of section B.]

1.8 Interpretation and application of Recommendation 6

Moderator: As with all aspects of health care, a prerequisite for evidence-informed care is to synthesise and interpret all available evidence, and WHO is the lead organisation in doing this in the form of Guidelines for use and adaptation by member states. This paper (Redesigning care for older people to preserve physical and mental capacity: WHO guidelines on community-level interventions in integrated care) takes the Guideline a step

further, analysing it and making further recommendations. The paper notes: 'One of the most challenging aspects of the process was generalizing the evidence to poorly resourced community healthcare settings'. For me, this is a critical point: the weak link in the translation of WHO guidelines is the lack of support for development and use of practical guidance. Such guidance needs to be firmly based on the evidence, and which is presented in a format, language and technical level that is appropriate for end users. (As Joseph Ana has mentioned in a previous HIFA message today, PACK is an excellent example of this.) WHO can make any number of recommendations in their Guidelines, but these will not be implemented in practice unless this weak link is addressed."

Moderator: I would argue that this problem applies to all aspects of health care, including and especially primary health care and empowerment of CHWs as part of the primary health care team. I would like to call for examples of evidence-informed guidance that is actionable by CHWs and the people who work with them. How is such guidance developed and made available? What are the challenges?

Moderator: Looking specifically at Recommendation 6 of the WHO CHW Guideline, on Supportive supervision, this recommendation (like all recommendations in the Guideline, and indeed all recommendations in all guidelines) will only make a difference if it is understood and interpreted (taking into account local contexts and realities) by those who develop national policy - and those who produce guidance for end-users.

Moderator: What materials are CHW trainers and others using currently to guide 'supportive supervision' in different contexts? How can the development and dissemination of such guidance be strengthened, so that this recommendation - and all other recommendations in the guideline - are translated into practice?

2. Recommendation 7: Remuneration

2.1 What the Guideline says

Recommendation 7 of the WHO Guideline on CHWs is in two parts:

Recommendation 7A: WHO recommends remunerating practising CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake.

Certainty of the evidence very low. Strength of the recommendation strong.

Recommendation 7B: WHO suggests not paying CHWs exclusively or predominantly according to performance-based incentives.

Certainty of the evidence very low. Strength of the recommendation conditional

Moderator: In the WHO guideline on CHWs, 'WHO recommends remunerating practising CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake.' Further, 'WHO suggests not paying CHWs exclusively or predominantly according to performance-based incentives'.

Moderator: I look forward to hear your views and experience on this issue of remuneration. How does the above relate to current practice in your country/experience? Is it implementable in your country/experience?

Moderator: The Guideline notes 'there appears to be no clear agreement on which strategies would best support CHW payment in ways that are beneficial, and policies and practices vary considerably in this respect across and within countries.' However, 'Despite the overall assessment of very low certainty of the evidence, the majority of reviewed studies were supportive of providing CHWs with a financial package.'

Moderator: The WHO CHW Guideline strongly recommends to provide a financial package to practising CHWs, despite the recognition of the very low certainty of the evidence. The rationale for this is described here:

'Despite the overall assessment of very low certainty of the evidence, the majority of reviewed studies were supportive of providing CHWs with a financial package. The GDG considered in its decision-making process also broader criteria, including best practice in relation to labour rights and legislation. This is crucial to align health policy to the broader international agenda on decent work, which entails opportunities for work that is productive and delivers a fair income; security in the workplace and social protection for families; better prospects for personal development and social integration; freedom for people to express their concerns, organize and participate in the decisions that affect their lives; and equality of opportunity and treatment for all women and men (129). The GDG was particularly concerned that models that rely on voluntary CHW work are inconsistent with the international agenda on decent work, and particularly with Sustainable Development Goal (SDG) 8, promoting decent work and economic growth. As most CHWs globally are female, the GDG was also concerned that continued reliance on voluntary work could perpetuate gender disparities in access to employment and income opportunities, and be inconsistent also with SDG 5 "Achieve gender equality and empower all women and girls" (130).'

2.2 CHWs: Volunteers and paid

Moderator: In our first major thematic discussion on CHWs, a recent study suggested there is potential for having two or more types of volunteer within a country, including volunteers who might work only a few hours a week, parallel with paid CHWs who work longer hours. Is this more pragmatic? Or should we be moving towards a situation where all CHWs are remunerated, including those who currently work a few hours per week as volunteers?

2.3 Performance-based incentives

2.3.1 What the guidelines says

Moderator: Recommendation 7B of the Guideline states: 'WHO suggests not paying CHWs exclusively or predominantly according to performance-based incentives.

Certainty of the evidence: very low. Strength of the recommendation: conditional]

Moderator: The narrative explains: 'The reputation of the CHW, as based on trust and respect from the community, can be negatively impacted by performance-based incentive schemes, which were described as at times being too narrowly focused on pre-identified indicators, leading to activities and efforts not linked to these indicators being ignored and unacknowledged. Performance-based incentives encouraged uneven focus on certain activities due to their association with higher incentives, especially when CHWs had no basic remuneration, leading to the neglect of other important activities or responsibilities. Other CHWs expressed dissatisfaction with performance-based incentive models in relation to amounts paid and inconsistent and incomplete payment of incentives (45, 143).'

2,3,2 Definition of performance-based incentives

Moderator: Perhaps the term 'performance-based incentives' needs to be clarified, as I could not find a definition in the Guideline.

Moderator: The USAID ASSIST project defines Performance-based Incentives as follows:

Moderator: 'Performance-based incentives (PBI) include both monetary and non-monetary incentives to encourage health-related actions or achievement of performance targets. Supply-side PBIs are used to improve the quality and availability of services. They are given to health care providers or managers at the facility, district, or national level, and are conditional on achieving service delivery or public health goals. Supply-side PBIs are now often being incorporated into national public health delivery systems, social insurance schemes, contracts with service delivery organizations, and safe motherhood schemes in low- and middle-income settings...'

'The 'PBIs have become a potentially important and powerful tool to improve health in developing countries. While much experience has been gained over the last several years in a variety of approaches, more evidence is needed about the implementation and sustainability of PBI interventions in low- and middle-income countries.'

<https://www.usaidassist.org/toolkits/improvement-methods-toolkit/performance-based-incentives>

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Moderator: Dear Alice, Thank you for your message of 5 November

[\[http://www.hifa.org/dgroups-rss/chws-40-performance-based-incentives-2\]](http://www.hifa.org/dgroups-rss/chws-40-performance-based-incentives-2)

You made two interesting points, namely that performance-based incentives can distort CHW's work because some tasks may be rewarded while others are not, and they can lead to forgery of outputs.

You do however imply that there is a role for such incentives, provided they are applied correctly: "Performance based incentives should also be linked to indicators that cover common conditions even if these are not linked to high mortality such as NTDs, skin conditions, epilepsy, mental health to a pick but a few. The incentive should cover quality time spent with the family or community and not simply the numbers reached or condoms distributed or number enrolled on FP."

The CHW Guideline (Recommendation 7B) states: 'WHO suggests not paying CHWs exclusively or predominantly according to performance-based incentives.'

As with most of the recommendations, the certainty of the evidence is low and the strength of the Recommendation is 'conditional'.

Personally, I find it hard to understand how performance-based incentives can work when they are simply a result of box-ticking by CHWs and their supervisors. It is one thing to recognise and reward CHWs who clearly do exceptional work, and by contrast to identify and support those who are the other end of the spectrum. Such rewards could and should include the opportunity for career progression. It is even reasonable to reward people according to the number of hours they do. But it is quite a different matter to pay CHWs according to how

many specified tasks they accomplish. Other health workers are not usually treated in this way.

I look forward to hear what others think about this. What is your experience of performance-based incentives (ie paying more to those CHWs who demonstrate the greatest outputs)? In your view, is there a role for such performance-based incentives in some settings, and if so how should these incentives be applied?

As a general comment, and I have mentioned this point in a previous message, it seems to me that the Guideline suggests What to do (Recommendations, mostly conditional) and Why (the evidence base, mostly weak, that underpins the Recommendation). But it says relatively little on the How - how to interpret these recommendations, and whether/how to implement them in policy and practice for different countries and settings. I mention all this not to question the guideline recommendations themselves more to gain perspective on country and organizational challenges on how the Guideline can best be interpreted and implemented in practice. Is there a role for a complementary "how to" publication that would integrate the guideline recommendations into a more practical manual?

Moderator: The more we discuss these issues, the more it seems to me that there needs to be a practical manual (or indeed series of manuals) to guide CHW program managers, linking with and referring to the Guideline. We mentioned earlier the Hesperian publication Helping Health Learners Learn. What other guides do you know of and how might they be enhanced by the new Guideline?

Joseph Ana, Nigeria: My comment: you are right in raising the risk of 'possibility of forgery of outputs'; but that is not a strong enough reason to not provide for and pay incentives over and above the basic salary. Basic salary in LMICs are almost always living wages for workers, including CHWs. If they are not paid incentives they seek to earn extra money elsewhere often doing such extra work during official working hours, or they indulge in corrupt practices like asking for cash before they even attend to patients or other visitors seeking public services.

Joseph Ana, Nigeria: Obviously they should not be taking bribes to do their work but they are tempted to do it (wrongly in my view but that is the reality). They claim to do it because that is the only way to pay their bills and take care of their families, including school fees and medical bills. At least if incentive is paid to augment their meagre wages, the bribery and corruption is limited and reduced to only those who are criminally minded anyway, but their numbers are usually a small minority. Those who administer an incentive programme must structure it to uncover forgery and other corrupt practices e.g. install internal verification and followed independent counter verification. It works in Nigeria State Health Improvement Programme (NSHIP) which is a World Bank Assisted programme run by Oxford Programme Management group (OPM) in primary health care in some pilot states. Those found to be guilty must be punished as a deterrent.

2.3.3 Performance-based incentives in India

Sanchika Gupta, India: The incentive system in India is not related to performance. They are involved in maternal, newborn, child care, adolescent, family planning, etc. programs. It is quite significant to understand her capabilities and involvement at the village level in additional healthcare programs in designing future programs.

Sanchika Gupta, India: ASHAs are incentive based worker in the public healthcare system in India. Incentive based worker means for each activity she will be given some money in her bank account. Sharing weblink of the government order on incentives.

https://nhm.gov.in/New_Updates_2018/communization/Aasha/Orders_and_guidelines/Official_orders/ASHA_Incentives.pdf

2.3.4 Performance-based incentives in Uganda

Alice Nganwa, Uganda: Performance based incentives should be applied after thorough understanding of the dynamics between CHWs, the community and the health institutions. Many donor-driven programmes have skewed service delivery by CHWs to HIV, TB, reproductive health and malaria to the detriment of other health services such as eye health, prevention of deafness and neglected tropical diseases which offer less or no 'allowance'. Some of the older and usually more trusted CHWs may also become frustrated when they are not rewarded according to their relatively high energy contribution which may be more thorough but covers less people/families than the superficial contribution of younger CHWs. The performance based incentive can also induce forgery of outputs. I was once shocked as I watched several CHWs forge family visits as they prepared to submit monthly reports. Even worse was their supervisor, a nurse who too did not want to submit data that indicated her team had not met its targets.

Alice Nganwa, Uganda: Performance based incentives should also be linked to indicators that cover common conditions even if these are not linked to high mortality such as NTDs, skin conditions, epilepsy, mental health to a pick but a few. The incentive should cover quality time spent with the family or community and not simply the numbers reached or condoms distributed or number enrolled on FP. Projectised service delivery should avoid putting pressure on CHWs to reach set targets because this could lead to forgeries.

2.3.5 Performance-based financing in Nigeria (note: this is not equivalent to individual performance-based incentives)

Joseph Ana, Nigeria: The Performance Based Financing (PBF) / Results Based Financing (RBF) programme pilot has been running in some states in Nigeria since 2012 (Nigeria State Health Investment Project (NSHIP)

(siteresources.worldbank.org/EXT/PBFTOOLKIT/Resources/7364043), and the impact so far is very impressive, so I was surprised to read that WHO recommends that it should not be used for CHWs. In Nigeria, of course, CHWs are an integral part of the primary health care system having gone through proper selection, trained under authorized curricular, posted to health facilities to serve and are subject to approved career path and emoluments including tenured pensions. At a recent interview of candidates for the Fellowship in PBF to appoint Technical Advisers who oversee the monitoring and supervision of the programme in the states, every one of the candidate agreed on the following summary in their presentations:

Definition: Result Based Financing (PBF) is an innovative, results-oriented approach that incentivizes providers based on their achievement of agreed-upon, measurable performance targets. Incentives could be financial and/or non-financial which include financial payments, bonuses, and public recognition

Joseph Ana, Nigeria: Core values of RBF / PBF: Assured financing, Managerial autonomy, Transparency, Accountability Right mix of resources, Constant refining

Joseph Ana, Nigeria: Paradigm shift in PHC where PBF operates: Financing (from input based to results based), accountability (fragmented and unclear to Defined with indicators and monitored), Investment (autonomy) (from Top to Bottom authority to By health facilities (bottom up), drug supply (distributed from central stores (mainly push) to Purchased by health facilities (mainly pull), performance (No verification to Independent verification and counter verification independently)

Joseph Ana, Nigeria: HOW RBF IS MAKING PHC WORK IN NIGERIA:

- Strengthened Governance and Leadership at all levels : Separation of functions; Contracts between the key players are tied to specific guidelines and outputs; Monitoring and Supervision; verification and counter-verification (checklists are sensitive to quality of care); Accountable leadership
- Improved Infrastructural Development : Health facility management autonomy (OICs are CEOs); Improved managerial capacity at the lower level; Development of business plan; Good health facility investment against investment at state and national level.; Accountability
- Improved Human Resource for Health : Ability to hire and fire by the health facility management; Appropriate cadre and number of staff are engaged without the usual political interference; Efficient service delivery
- Drugs and Medical Materials Supply: Institutionalization of essential drug management and DRF; Decentralized drugs and medical supplies procurement; Ensures availability at all times
- Promotion of Equality and Equity in Access to Health Care : Care of the indigents; Equity categorization of health facilities; Some service in the packages are free; Conditional Cash transfer (CCT); Improvement in the demand side of health care
- Funding: Ensures that funds get to the operational level (LGA and HF levels with little or no bureaucracy; Funding/ resource allocation takes into cognizance the outputs/performances of the health facilities.
- Community Participation & ownership: WDC establishment/reactivation (WDC chairman is also the HF RBF Committee Chairman); Quantity counter-verification (CCSS by the CBOs); Accountability

Joseph Ana, Nigeria: Feedback / conclusions of the participants on PBF in Nigeria PHC:

- Performance Based Financing (PBF) has brought about a positive effect by reducing challenges of Primary Health Care in particular and the health care system in general.
- Output financing approach will put an end to: Predominance of Top- Down management in health system; Stagnating health outcomes; High rates of mortality and morbidity etc. Output financing approach will definitely have a positive influence on health service delivery in Nigeria.
- Globally, PBF remains the gold standard to achieving UHC
- Healthcare system in Nigeria is encumbered with a number of systemic and structural challenges. However, result-based financing programmes in some countries have shown potentials for improving health system accountability and responsibility, healthcare coverage, service delivery and capacity to reaching the very poor and under-served (Ashir et al., 2013; Grittner, 2013).
- RBF is the most efficient and cost effective health care system delivery. It improves both quantity and quality of services. And it has all the potentials to achieve Universal Health Coverage (UHC) and those of the SDG.
- Nigerian health system which was largely an input-based is weak and characterized by low funding, poor infrastructure, inadequate technical staff etc. There is urgent need for a paradigm shift from input-based to output-based i.e Performance-based financing (PBF)

looking at various benefits associated with the later. Form of input financing i.e PBF has been partly practice in few Nigerian states including; Adamawa, Nassarawa, Ondo and few states in north east of the country as pilot.

- Good collaboration among the six WHO pillars of Nigerian Health system; Enhanced community ownership and participation; Adequate supply of essential drugs, consumables and tools; Health workers are motivated to carry out their duties professionally; Enhanced proper planning, implementation, monitoring and evaluation of health system; Adequate personnel with more professional quality; Improved health care services qualitatively and quantitatively.

- Performance Based Financing is the way to go in Primary Health Care in particular and the health care system in general. I hope and wish that performance based financing has come to stay because the results are very evident especially in Mubi South Local Government Area where I come from.

3. Recommendation 8: Contractual agreements

3.1 What the Guideline says

Recommendation 8 of the WHO Guideline on CHWs states:

'WHO recommends providing paid CHWs with a written agreement specifying role and responsibilities, working conditions, remuneration and workers' rights.

Certainty of the evidence very low. Strength of the recommendation 'strong.'

Here is the background to this recommendation:

'Because CHWs work at the interface of community and formal health care systems, their role and identity within the health care structure has historically lacked clarity. The importance and impact of CHWs with regard to health care delivery are generally well recognized and acknowledged within the sector. However, contracts and agreements have the potential to explicitly and formally determine the responsibilities that CHWs should fulfil, as well as the rights and benefits they are entitled to, and they could represent a tool to more formally integrate CHWs into the health care system. Formal contracts in this context are defined as written agreements specifying CHW working conditions and rights, job responsibilities, duration of employment and remuneration terms.'

'It is assumed that contracts can serve as an incentive and contribute to job stability and security, and enhance occupational protection and safety. Furthermore, formal contracts set the groundwork for professional development, as they typically require or encourage employers to support professional development opportunities and supervise workers. The advantage for the health system is provision of a basis for CHW accountability.'

4. Recommendation 9: Career ladder

4.1 What the Guideline says

WHO suggests that a career ladder should be offered to practising CHWs, recognizing that further education and career development are linked to selection criteria, duration and contents of pre-service education, competency-based certification, duration of service and performance review.

Certainty of the evidence “ low. Strength of the recommendation conditional.

'Providing health workers with a career ladder (that is, opportunities for progressive advancement to higher-level positions in a health system, or upgrading skills and expanding roles) is universally seen as a good practice to reinforce both motivation and retention... offering CHWs a career ladder after some years of satisfactory service can potentially include improved motivation and job satisfaction, contributing to increased retention and reduced attrition.'

'The GDG was of the view that the benefits of offering CHWs a career ladder after some years of satisfactory service can potentially include improved motivation and job satisfaction, contributing to increased retention and reduced attrition. The GDG concluded that these benefits outweigh potential shortcomings linked to depleting the pool of practising CHWs, and, on the contrary, that career ladder schemes and frameworks can contribute in a positive way to upward social mobility aligned to the Decent Work Agenda. On this basis, while considering the minimal supporting evidence, the GDG adopted a conditional recommendation in favour of providing CHWs with a career ladder framework.'

'WHO suggests that a career ladder should be offered to practising CHWs, recognizing that further education and career development are linked to selection criteria, duration and contents of pre-service education, competency-based certification, duration of service and performance review.'

Here are some further key points from the Guideline:

1. 'The stakeholder perception survey found that offering CHWs a career ladder opportunity is acceptable, but its feasibility might be variable across different contexts...
2. 'The GDG interpreted the lack of evidence on this aspect as a reflection of the limited availability of career ladder opportunities for CHWs in most settings, resulting, correspondingly, in the absence of formal evaluation of such (non-existing) schemes...
3. 'If compatible with the pre-existing education level, offering CHWs a career ladder might entail a route to progress to other health qualifications, subject to completion of required additional training. In the case of lower level of educational attainment than the minimum required for training for other health professions, alternative modalities of career ladder might entail progressing to CHW managerial posts (for example, senior and well performing CHWs advancing to roles that entail contribution to education, supervision and management of less experienced CHWs).'

Moderator: With regard to [1] feasibility of implementation, would anyone be willing to comment, based on their observations/experience?

Moderator: With regard to point [2], is 'limited availability of career ladder opportunities for CHWs in most settings' true in your experience? What impact does this have on CHWs?

Moderator: On point [3], this aligns with our discussion so far on this subject: in theory, there is potential for CHWs to be promoted 'within the CHW system', and there is perhaps also potential for CHWs to move into higher training as nurses or other professional cadres. In practice, are both these routes feasible, at least for some CHWs? Can you give examples where CHWs have progressed in this way?

Moderator: For me (as a non-expert), this is one of the most important recommendations in the Guideline, because it represents (as far as I know) the first official recognition that becoming a CHW has the potential to develop into new career possibilities. It also makes a lot of sense as it gives the CHW autonomy and the potential to plan ahead, thereby providing motivation to excel. In the past, I understand that there has been a 'glass ceiling' for some CHWs, whereby they are 'stuck' at the same level indefinitely. At the same time, there will always be some CHWs who love their job and who want to stay and continue to develop in their current role.

Moderator: One aspect of career progression could be to educate, supervise and manage less experienced CHWs. Selected CHWs could also have the opportunity to enter training to become 'higher-level' health professionals.

Moderator: The latter would hopefully be welcomed by 'higher-level' health professionals, some of whom have expressed concern about the expanding roles and responsibilities of CHWs, and the perceived neglect of other primary health workers. Hopefully, a career ladder whereby some recruits into professions such as nursing have a background as CHW would only enhance the cohesion of the primary health care team - so important and, it seems, sometimes lacking.

Moderator: I am reminded also of the PACK approach, whereby the same manual is used by all primary care workers, thereby promoting cohesion.

Moderator: Career mobility through all levels of the health workforce, together with common tools for clinical decision-making, has the potential for transformative change and improved patient care.

Moderator: We would be very interested to hear of examples of career ladders in practice (or, conversely, examples of barriers to career progression among CHWs).

Moderator: What are your thoughts on career progression for CHWs? How can they be more supported to apply for new training courses and positions?

Moderator: What are the current career opportunities for CHWs in your country or setting? What opportunities are there for CHWs to advance their career, either through different 'levels' of CHW (eg further special interest training, CHW trainer position or CHW programme management/administration) or through promotion into higher educational training (for example, nursing, midwifery, clinical officer, pharmacist, doctor)?

Moderator: More broadly, what has been your observation with CHW ambitions and retention? Do they tend to see CHW work as a stepping stone to new opportunities? if so, how can their career journey be better supported? What opportunities do they have to continue to develop within the health sector?

Moderator: Perhaps the current set-up for CHWs in your country has limited or no opportunities for career progression? If so, what do you see as the challenges to provide such opportunities?

Moderator: If you have already created or observed new opportunities for CHWs, we would especially like to hear from you.

Rosemary Bolza, USA: I have worked with Community Health Representatives on the Navajo Nation [*see note below] and many different health 'extenders' such as family planning counselors, breastfeeding peer counselors in the WIC program and domestic violence advocates. There are many valuable education seminars for them but they never get academic credit. So these are often dead ends as careers. My dream is to develop a pre nursing course for the community college level that would include the learning from these trainings so the training becomes the beginning of a career. Knowing about family planning, breastfeeding, and domestic violence would be valuable for all nurses and other health professionals as well as provide this training to those wanting to do these jobs themselves. I would like to join with others who would be interested in developing such a course.

[*Note from HIFA moderator (Neil PW): 'The Navajo Nation is an American Indian territory covering about 17,544,500 acres, occupying portions of northeastern Arizona, southeastern Utah, and northwestern New Mexico in the United States.'

https://en.wikipedia.org/wiki/Navajo_Nation]

Catherine Kane (to Rosemary Bolza): What an interesting idea. I think there is a great deal of potential. One avenue may be to look at universities and colleges that have community health tracks. A colleague this week will be talking with someone from CUNY (City University of New York) regarding health workforce considerations within community health coursework. I'll try to get a sense of where their conversation goes.

Catherine Kane (to Rosemary Bolza): Community health workers perform such a variety of roles in such a variety of contexts, and we sometimes only look in low- and middle-income country contexts. Your comment/inquiry shows both the importance of CHWs in reaching specific populations (in this case Native Americans) and of creating potential avenues for people to continue developing their skills.

Rosemary Bolza, USA (to Catherine): Community Health workers are best accepted when they are from the community they work in. Depending on the community there may be limited access to community colleges or other institutions that give academic credit but as the world becomes more urbanized and as educational institutions look to offer training in flexible ways the possibility of community Health workers training being part of an educational program that gives academic credit is more possible. The First Nations of Canada have developed midwifery training that works with and credentials the village midwives.

Rosemary Bolza, USA (to Catherine): I also worked with WIC [Women, Infants, and Children] breastfeeding peer counselors and domestic violence and sexual assault advocates. There is innovative training available for all of these positions which may be paid or unpaid. I realized that these trainings would be very valuable for nurses and other health professionals. Most health professionals have prerequisites before entering their programs. A course on human reproduction that includes how to work with people to explain and understand family planning methods, supporting breastfeeding and responding to sexual violence would be valuable for those planning to work as family planning counselors, breastfeeding counselors, and advocates for victims of sexual violence and also health professionals from nursing assistants to Medical Doctors.

Massimo Serventi (to moderator): I think that in your comment on 'ladder of career' for CHWs you forgot one essential thing: CHW are nowhere employed/salaried by their respective system of health. They are a product of NGOs working in Africa.

Catherine Kane, Switzerland (to Massimo): We should find within this discussion that there are a number of varied CHW programme models, including those with salaries, incentives and volunteer roles. Similarly, some programmes are run by ministries or district health, while many are indeed run by NGOs. We encourage all players with CHW programmes to align those efforts with ministries of health, in order to better align selection, training, supervision, supply, data... I also think that being NGO-supported does not preclude a career ladder.

Catherine Kane, Switzerland (to Massimo): While not all CHWs are interested in a career progression some will provide village level services for years for others, the CHW role can become a stepping stone. The presence of well-trained and supported CHWs in communities should also contribute to strengthening community leaders' understanding of the importance of education... thus leading to potentially opportunities for young people to achieve higher levels of basic education with the goal of becoming CHWs.

Catherine Kane, Switzerland (to Massimo): I can see from your bio that you have worked in a number of countries in Africa and Asia. As we look to find out more about countries and their context for CHWs, it would be great if participants in the discussion add their country(ies) and those contexts so we can understand more about the overall landscape and look to promote optimising this work.

Mohammad Ali Barzegar, Iran: Regarding the CHW career progression, In Iran where the CHWs (BEVARZ), are the part and parcel of the health system and are formally recruited by the Ministry of health& Medical education since 1973 and some of them already have been retired after 30 years of services, CHWs progression is as follow:

Mohammad Ali Barzegar, Iran: After at least 10 years of excellent services in HEALTH HOUSE, she or he will be promoted as Senior BEHVARZ at Health Houses. Her/His new role will be as assistant supervisor and instructor for the newly trained BEHVARZ in the Health House After some years services in this position and gaining experiences. She will be posted in the CHW Training Center as assistant Instructor, who will assist in teaching of new batches of CHW, mainly in practical sessions in class and supervision in the field and health houses in the village. After some years experiences as assistant instructor and proving herself and passing some tests and evaluation by the Instructors and manager of the CHWS Training Center she will be promoted to INSTRUCTOR of the CHW Training Center. Finally the best one could be assigned as the manager of the CHW Training Center after receiving some short term courses on management of the training center. Needless to say that we do not push them to go to the nursing or medical school. But if some of them take part and pass the National Entrance Exam for medical or Nursing school they, will be allowed to join and after graduation they will be recruited by the ministry of health with their new degree. But to my knowledge it was very rare.

Mohammad Ali Barzegar, Iran: In my points of view, as far as the training system of CHWs is completely different from the training system of Medical & Nursing school in terms of community based and problem solving approach, I would recommend that their promotion

goes within their own system. Except until the educational system of medical & nursing school be reorient towards community oriented one.

Rosemary Bolza, USA: When I was on the Board of the Navajo Nation Family Planning Corporation I saw that time and money was spent training the counselors. Many of the counselors did an amazing job but none of the training they went through gave academic credit. The counselor position were entry level jobs. The requirement for employment was a high school diploma and then when hired they went through the training and started doing the counseling in federally funded clinics. I believe the content of the training is available and could be adapted to a community college course but as a practicing midwife I did not have the time or energy to do this.

Joseph Ana, Nigeria: I share some of Massimo's opinion about CHW such as motivating them. And I understand why he thinks that a new cadre is not necessary, but I also know that his suggestion that the community should remunerate / pay the CHW is not practical given the deprivation and poverty in the communities where these CHWs operate.

Joseph Ana, Nigeria: If a Government is too poor to pay CHWs even though it employs them, there is a problem, often the lack of prioritisation of health as a Human Right of every citizen. Where Health is so prioritised, the country puts in the necessary resources to fund governance, training, infrastructure, equipment, human resources including CHWs, and more. Those countries that have achieved Universal Health Coverage (UHC) even before the UN took the decision to call for it, have all put the Health of their citizens at the top of the Agenda.

Joseph Ana, Nigeria: Many members may not be aware that Britain / UK has an election on 12th December 2019, so the campaigns are on - if you have the access, please watch it on the international news channels. You will see how the National Health Service of UK (NHS) is at the top of all the political party manifestos. The Political parties are falling over themselves to be the Party of NHS. I don't know any LMIC or African country where Health receives the same attention. Maybe Rwanda is doing so, lets know please.

5. Recommendation 10: Target population size

5.1 What the Guideline says

WHO suggests using the following criteria in determining a target population size in the context of CHW programmes.

Criteria to be adopted in most settings:

- expected workload based on epidemiology and anticipated demand for services;
- frequency of contact required;
- nature and time requirements of the services provided;
- expected weekly time commitment of CHWs (factoring in time away from service provision for training, administrative duties, and other requirements);
- local geography (including proximity of households, distance to clinic and population density).

Criteria that might be of relevance in some settings:

- weather and climate;
- transport availability and cost;
- health worker safety;
- mobility of population;
- available human and financial resources.

Certainty of the evidence very low. Strength of the recommendation conditional.

Moderator: How feasible is Recommendation 10 in your country/context to determine CHW:population ratios taking these factors into consideration? If your country/programme currently does this, what tools do you use?

5.2 CHW workload

Edwin van Teijlingen, UK/Nepal: I have a slight worry that we simply producing a long wish-list with too many things to do for any CHW (or team of CHWs) and thereby setting them up to fail in the long run.

Moderator: Is there any evidence in your country that CHWs are being expected to do too much? Are we setting CHWs up to fail? This might be through many factors:

1. A situation where a CHW is expected to provide services single-handed (Are such situations common, where a single CHW is expected to be the first frontline health worker for all health situations across the community? Or can CHWs be deployed in teams, where they might have complementary skills in different aspects of health?)
2. Situations where the CHW is overwhelmed - whether constantly or intermittently - because of excessive numbers of people they are responsible for.
3. Situations where the CHW is frequently faced with health crises for which they are not adequately trained and/or where there is insufficient support or referral systems.

6. Other issues relating to CHWs

6.1 Role of CHWs: Treatment

Takang Arrey, Cameroon: I have got great worries about empowering CHWs with curative skills. In my context, I think we should empower them mostly with health prevention and promotion information. They actually are working without any proven legislation apart from training got from NGOs sponsored by global fund or programs which are in need of their services at that particular time. They actually misuse this curative empowerment and become "docta" overnight. Some go to the extent of prescribing and selling drugs to the Community members whom they served.

Dan Irvine, USA: I greatly appreciate your message regarding the CHW situation in Cameroon. It highlights quite a number of challenges. I would certainly agree that CHWs

require proper training and supervision for any task they are officially commissioned for. And certainly the MOH should have oversight of national CHW programme investments. A few years back we published a "CHW Principles of Practice" which advocates that all CHW investments in a country should be aligned with a singular national policy and framework (<https://www.wvi.org/health/publication/chw-principles-practice>).

Dan Irvine, USA: That said, the disease treatment potential of CHWs is well documented, and proven to make a life saving difference for vulnerable populations who are often out of effective reach of front line health facilities. Integrated community case management by CHWs does need to be carefully administered and supervised - that's a question of system integrity, and where our careful focus should be.

Takang Arrey, Cameroon (To Dan Irvine): In the advent of task shifting, there are certain tasks attributed to Community health workers within their serving Communities such as those in the management of integrated childhood diseases package known by its french acronym PCMI "prise en charge des maladies infantile". Here our CHWs are to treat diarrhoea diseases with ORS, acute respiratory infection with Cotrim, acute UTIs with amoxicilin, malnutrition with enriched pap. A considerable good strategy for our vulnerable, poor and geographic inaccessible populations whose health has been left in the hands of CHWs who are trained per program, never supervised by MOH officials or even by the lone Community health nurse. Thus these CHWs tend to abuse their job description to the point where some of them have opened personal pro-pharmacies in their homes. This is where my worry lies with our health system per WHO 2014 recommendations on CHWs training and practice. We need a Framework consisting of a set of rules/norms to govern these other actors integrated in the health system who are the first referral link to the system.

6.2 Urban CHWs

Lilian Otiso, Kenya: As part of our work in the REACHOUT consortium (<http://www.reachoutconsortium.org>) we noted some differences in CHWs in urban settings compared to those in rural areas in Kenya. We noted differences in the community set up with high mobility of informal urban settlement dwellers, differences in community participation and gender norms across the two settings. There is limited literature on this topic especially on CHWs in urban contexts. What are the experiences in other countries? Is there any literature that anyone would like to share on this?

Azeb Tesema, Australia: Yes, there are some differences between the urban and rural CHWs program that we have in Ethiopia too. You can find brief overview from this paper, <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-3868-9>

Azeb Tesema, Australia: I am conducting a study to explore the role of both the rural and urban Ethiopia health extension workers in NCDs prevention and management services. Though I am still in data collection process, happy to share some preliminary findings in later times.

Catherine Kane (to Lilian Otiso) Among other resources, you may be interested in disease programme guidelines that address reaching specific population groups like migrants and nomadic persons as well as groups that either experience stigma and discrimination or may not seek services due to political or legal barriers. CHWs particularly those selected from the target populations may be more able to deliver services and gain the trust of these people.

You'll find some examples in the ENGAGE-TB approach, for example:
<https://www.who.int/tb/publications/engage-tb-implementation-manual/en/>.

6.3 CHWs in Nigeria

Joseph Ana: Nigeria: already meets all the WHO Guideline recommendations for contracting, career progression, financial motivation etc, as contained in the National TaskShifting Policy of 2014: <https://www.psi.org/wp-content/uploads/2016/09/5.-Nigeria-FMOH-Task-sharing-presentation-071116-3.pdf>

In Task-shifting and Task-sharing policy for essential health care services in Nigeria by federal ministry of health published in August 2014, the Minister of Health stated in his Foreword which he signed, that

'Unfortunately, when the older health care workers are retiring, they are not being replaced. Conversely, in some parts of the country, there are many employed but under-utilized health care workers who can be trained to competency and given specific responsibilities for the care of vulnerable Nigerians in hard to reach areas. Community health extension workers belong to this group.

The development of this National Task Shifting and Sharing Policy is a major leap towards the scaling up of access to effective and evidence-based essential health services in Nigeria. It is aimed at increasing access to services currently included in the essential health package in an effort to significantly reduce Nigeria's unacceptably high mortality ratio/rates and to achieve set Millennium Development Goal (MDG) targets for the country.

Its approval will lead to curriculum changes for pre-service education and in-service trainings of different cadres of staff and production of more knowledgeable and skilled health care workers. For example, female CHEWs (Community Health Extension Workers) can be trained to provide normal delivery services and to identify and initiate the management of the common complications of pregnancy and childbirth. Midwives can be trained to provide long-acting reversible contraception like intrauterine devices and implants while NYSC doctors can be trained to perform manual removal of a retained placenta. Volunteer health workers can be trained to counsel pregnant women about the benefits of HIV testing in pregnancy and to support those on antiretroviral therapy.

These measures are temporary and are not designed to take away tasks from any professional groups but rather to make the best use of the cadres of staff currently employed and deployed to our health facilities. The implementation of this policy will be reviewed every five years as more health care workers are produced and employed in the sector."

The minister continued in his Foreword to the document that "Therefore, the policy focuses on key priority areas in which the CHW shall be trained include (such as) Family and Reproductive Health, Maternal and Child Health services (RMNCH), as well as HIV, TB, Malaria and other communicable and non-communicable diseases in Essential health services package. The essential health services shall include the following (as itemized in the National Health Strategic Development (NHSDP) 2010-2015: Family Health (Ante-natal care, delivery and new-born care; post-natal care; Family planning; Child health integrated Management of Childhood Illnesses (IMCI); growth monitoring and essential nutrition; immunization; Adolescent reproductive health); Communicable diseases (Tuberculosis (TB)

and leprosy; HIV/AIDS and sexually transmitted infections; Epidemic diseases (including malaria surveillance); rabies); Basic curative care (Treatment of major chronic conditions); Hygiene (Hygiene, Water-borne diseases); Environmental health; Health education (Health education and communication).

It is important to show that CHW are fully integrated in the Nigeria health system by quoting the Recommendations in the Task Shifting policy of 2014 cited above with provisions for career progression and financial motivation [see here for all 23 recommendations: <http://www.hifa.org/dgroups-rss/chws-47-contracting-agreements-2>]

6.4 'Specialist CHWs'

Moderator: "This is yet another area where CHWs can be trained to deliver specific tasks. In our discussion on CHWs, we tend to talk about them in generalities and forget that (a) the number of potential tasks that could be undertaken by CHWs is far more than could ever be expected of one cadre, and (b) CHWs are in fact a highly heterogeneous group with diverse training needs. Many (an increasing percentage?) CHWs could be described as 'specialist CHWs', like the ones engaged in the above study. I am not sure we (or the CHW Guideline) have got to grips with this diversity and how to manage it. The Guideline notes that there can be no such thing as a universal curriculum, which had previously (and perhaps still is?) been promoted by many. Perhaps there is a case for a 'basic CHW training' followed by 'specialist CHW training'?"

Moderator: It is clear that 'specialist CHWs' exist, and that they are necessary and will become increasingly so. Joseph's comment demonstrates the high continued sensitivity of CHWs as a concept, whereby terms such as 'specialist' are likely to be misunderstood and resisted.]

Joseph Ana, Nigeria: 'Specialist CHWs' and any such terminologies would deal a death nail to the whole CHW movement in many countries. We must remember that the concept is yet to be universally accepted in many countries, so beginning to call CHWs 'specialists' risks very serious backlash. Lets hold on to just CHW for the foreseeable future, even if they are trained in single curriculum arrangement. More important is defining their meaning and role; intensify the advocacy that they are accepted in the first place; undergo clearly structured training; and thereafter receive supportive supervision and monitoring of their performance; motivate them to go home with living wages; etc. [*see note below]

6.5 Role of CHWs

Mulenga Lwansa: My humble contribution CHW are very important to us and in as much as we quantify our labour we can as well do that for them. Remember they are bridging a gap we the paid workers have failed to bridge.

Massimo Serventi, Tanzania: CHWs ideally should be remunerated by their communities, this is nowhere the case in the world. If we accept the idea that CHWs must be recruited and remunerated by their governments we also accept that they become nothing different from other ordinary health workers, in rural areas.

Massimo Serventi, Tanzania: Well, poor countries suffer from serious budget constraints, many doctors (how much money has been spent for them!?) are not employed for lack of

budget, they run away. In this situation the logic approach is to optimize the work of staff already in place and not to employ new ones.

Massimo Serventi, Tanzania: I wrote several times: ordinary health workers in rural areas need much of support, they feel isolated and neglected. They are recognized and valued by their communities as their natural health providers. If adequately motivated and oriented they could become excellent community health workers. Why not direct our attention to them?

Massimo Serventi, Tanzania: I conclude: it is a mistake to introduce any new program in the fragile system of a poor country, it will not last long.

Massimo Serventi, Tanzania: The last paragraph applies perfectly to the approach on malnutrition 'invented' in France (plumpynut) and somehow imposed (yes: imposed!) to governments of poor countries.

Unicef love the idea of plumpynut, how many containers of it enter in Africa every day? India (that has the highest absolute number of malnourished children) has refused plumpynut. Most poor countries, mainly subsahara countries have accepted, obtorto collo. [reluctantly]

Jean Bosco Gasherebuka, Rwanda: I totally agree with Massimo about CHWs. Many countries are not able to remunerate them. The only best and efficient way is to put in place innovative ways of motivation for sustainability. Rwanda is using such strategies and it's working well.

6.6 Voice of CHWs

David Musoke: As many of you will agree, the voices of Community Health Workers (CHWs) are not heard enough, and many times the opportunities for them to take part in local, national and international engagements including conferences is minimal. As we prepare for the 2nd International Symposium on CHWs to be held in Dhaka, Bangladesh from 22 to 24 November 2019, I am sharing a quotation from a CHW following his presentation in a plenary session of the 1st CHW Symposium held in Uganda in 2017. My hope is that there will be many CHWs attending the symposium in Dhaka next month. [*see note below]

David Musoke: "Being able to speak at such a high-level symposium was like a dream come true for me. As a Community Health Worker in Uganda, our opinions are many times not listened to therefore being able to share our experiences and challenges with an international audience was great. It also seemed that the participants were very interested in hearing my perspectives amidst several other presenters. It was humbling to receive an overwhelming applause from the audience after my presentation." Henry Bugembe, Community Health Worker, Wakiso District, Uganda

6.7 CHWs and violence against children

Dan Irvine (USA): Violence against children affects an estimated 1.7 billion children every year, and roughly half of all children have experienced some form of emotional, physical or sexual abuse during their childhood. Violence against children in all its forms (physical, sexual and emotional abuse, as well as neglect and exploitation) robs children of their human rights, dignity and future - the opportunity to fulfil their potential. Violence has a negative impact on childhood health and development, and can severely impair a child in adult life, as well.

Dan Irvine (USA): Recently, there has been increased global interest in strengthening the health sector's role in ending violence against children and evidence-based strategies have been recommended. These strategies describe approaches in which community health workers can play a key role through educating parents, promoting caregiver skills, identifying children and families at risk, and providing community-level referrals for child protection interventions. Given CHWs' proximity to communities and families, and their widespread distribution in under-served communities, they offer a promising opportunity to scale up interventions to end violence against children globally. The contributions of CHWs have been widely recognised in prior studies for their role within community-based interventions in improving social behaviour for health and nutrition. Yet, of the vast literature on CHWs' practices, there is scant global research on perceptions and practices of CHWs in preventing violence against children, and in their potential role in reducing it. Furthermore, the voices of CHWs themselves in such policy debates are rarely put forth and heard.

Dan Irvine (USA): In the 2019 study "Understanding community health workers' perceptions and practices in preventing, detecting and responding to violence against children", World Vision interviewed 412 CHWs in four countries - Bangladesh, Myanmar, Kenya and Tanzania - regarding their roles in preventing and detecting, as well as responding to all forms of violence including existing support and training, plus barriers and enablers they perceive. In the four countries surveyed, CHWs witness violence against children at a very high rate in their work, confirming official data about the prevalence of varied forms of violence in each country. Overall, 76% of CHWs reported observing any form of violence against children during the course of their work, with neglect (54%), child marriage (40%), harsh physical punishment (40%), and verbal abuse (36%), as most commonly observed.

Dan Irvine (USA): Most CHWs believed their role encompasses preventing and responding to violence against children, and over 60% reported taking action after witnessing abuse. Over 72% of CHWs reported that preventing, identifying and responding to violence against children are currently within their role. CHWs were highly motivated to receive training on violence against children-related issues, with over 54% listing violence against children topics in their top three training needs, and 58% reporting the desire to be trained on violence against children. Of the 81% of CHWs that reported receiving any training in the last 12 months, only 23% reported having any violence against children-related training in the last 12 months. 92% of CHWs reported having a supervisor, and 79% reported three or more supervisions in the last three months, but only 45% of CHWs reported having discussed a violence against children-related case with their supervisor. This suggests supervisors are under-utilised as support for violence against children issues in communities.

Dan Irvine (USA): Full Text: <https://www.wvi.org/publications/report/it-takes-world/it-takes-community-health-workers-end-violence-against-children>

6.8 CHWs and violence against children

Rebecca Furth, USA: Read CHW Central's latest feature 'Can CHWs Help End Violence Against Children' <https://www.chwcentral.org/blog/can-chws-help-end-violence-against-children> to review current evidence on the roles of CHWs in addressing violence against children (VAC). This engaging and important feature, written by Polly Walker of World

Vision International, highlights CHWs' work on the frontlines and notes the degree to which they are already involved in identifying, mitigating and preventing VAC.

7. Interpretation and application of WHO Guideline

7.1 CHWs and care of elderly

CITATION: Redesigning care for older people to preserve physical and mental capacity: WHO guidelines on community-level interventions in integrated care

Jotheeswaran Amuthavalli Thiyagarajan, Islene Araujo de Carvalho, Juan Pablo Peñã-Rosas, Shelly Chadha, Silvio Paolo Mariotti, Tarun Dua, Emiliano Albanese, Olivier Bruyère, Matteo Cesari, Alan Dangour, Amit Dias, Mariella Guerra, Jill Keefe, [...], John R. Beard

Published: October 18, 2019 <https://doi.org/10.1371/journal.pmed.1002948>

<https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002948>

SUMMARY POINTS

Numerous underlying physiological changes occur with increasing age, and for older people, the risks of developing chronic diseases and care dependency increase.

Health systems are often better designed to respond to episodic health needs than to the more complex and chronic health needs that tend to arise with increasing age, and reprioritization is required to meet the needs of ageing populations.

Significant losses in capacity and care dependency in later life can be delayed or avoided if health interventions are introduced earlier in the process of functional decline.

We discuss the recommendations of the WHO Integrated Care for Older People (ICOPE) Guidelines, which provide evidence-based recommendations for managing declines in intrinsic capacity, developed with the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology.

Implementation of evidence-based interventions requires community-based assessment of an individual's needs, development and implementation of a care plan, provision of monitoring and referrals as needed, and supporting caregivers.

BACKGROUND

Today, for the first time in history most people can expect to live into their 60s and beyond [1]. In low- and middle-income countries, this is largely the result of large reductions in mortality at younger ages, particularly during childhood and childbirth, and from infectious diseases. In high-income countries, continuing increases in life expectancy are now mainly due to declining mortality among those who are older. Even in sub-Saharan Africa, which has the world's youngest population structure, the number of people over 60 years of age is expected to increase over 3-fold, from 46 million in 2015 to 147 million in 2050...

The paper discusses the WHO Guidelines on Integrated Care for Older People (ICOPE) [11] published in 2017 and presents recommendations on community-level interventions to manage declines in intrinsic capacity.

As with all aspects of health care, a prerequisite for evidence-informed care is to synthesise and interpret all available evidence, and WHO is the lead organisation in doing this in the form of Guidelines for use and adaptation by member states. This paper (Redesigning care for older people to preserve physical and mental capacity: WHO guidelines on community-

level interventions in integrated care) takes the Guideline a step further, analysing it and making further recommendations. The paper notes: 'One of the most challenging aspects of the process was generalizing the evidence to poorly resourced community healthcare settings'. For me, this is a critical point: the weak link in the translation of WHO guidelines is the lack of support for development and use of practical guidance. Such guidance needs to be firmly based on the evidence, and which is presented in a format, language and technical level that is appropriate for end users. (As Joseph Ana has mentioned in a previous HIFA message today, PACK is an excellent example of this.) WHO can make any number of recommendations in their Guidelines, but these will not be implemented in practice unless this weak link is addressed.

8. Reflections from the Dhaka Symposium

8.1 Joseph Ana

It was a hugely successful meeting with participants from many countries (rich and not so rich) and groups: about 35 countries, The WHO, UNICEF, DFID, ILO, Save The Children, UNFPA, development partners (USAID, etc), non governmental organisations (e.g. Population Council's Frontline Health Project, Bill and Melinda Gates Foundation, Last Mile Health, etc), civil societies organisations, health professional associations, private health sector, individuals, others. Especially significant was the participation of representatives of CHWs from Bangladesh in particular, whose efforts have placed the host country at the centre of the Global effort to advance the positive contributions of CHWs, and to steer the world to understand that given the present structure of health systems in most countries including the LMICs, it is safe to say that without CHWs PHC will be difficult (if not impossible) to achieve and without PHC the global aspirations of UHC (with no one left behind) and SDGs by 2030 are not attainable.

For me the climax of the three day symposium was the launching of the Bangladesh Strategy for Community Health Workers (2019-2030) document. Apparently, the first country to do so. It is a 33-page document in which the Minister of Health and Family Welfare (MOHFW) of Bangladesh declared in the Foreword, that 'Bangladesh has achieved immense success in the health sector. The Prime Minister received an award for achieving the MDG in health and very recently (November 2019) received the VACCINE HERO award from GAVI for our achievement in vaccination programme. I believe that the national action plan will follow this strategy document launching

The Secretary, Health Services Division of the MOHFW emphasised the role of CHWs in his own message by stating that 'the current (Bangladesh) health system and workforce is gaining momentum to go for UHC. In particular in this crucial journey community health workers are very vital and essential -----'. The Director General of MOHFW went further to say in his own message in the strategy document that 'Bangladesh has been one of the first countries to develop national scale cadres of CHWs beginning in 1960s with its smallpox and malaria assistants followed by the deployment of oral rehydration solution (ORS) workers by BRAC in the 1970s. Even though Bangladesh is a country with shortage of public sector health workers, it has made unprecedented and rapid progress in several health indicators and outcomes with sincere and relentless contributions from the community health workers

(CHWs)'. He went on. 'The strategy gives special importance to e-record keeping and reporting. The advanced digital reporting system already in place (DHIS-2 programme) is making the CHWs work more effectively and also reduces their workload. It helps the supervisors to provide better supportive supervision to the CHWs.'

The CHWs are mainly women in Bangladesh because they have proven that they commit to staying in the system with less attrition, unlike the men. They (CHWs) are about 180,000 for the country population of 160 million. They are permanently resident in their location and work from the community clinics, each clinic serving about 6000 population since 1990. The clinics are a form of Public Private Partnership under the Community Health Support Trust since 2018 for sustainability reasons in the long term. With the services of CHWs, Bangladesh has recorded significant increases in her health indices: Maternal Mortality down by 75%, Infant Mortality down by 50%, Immunisation increased and stands at 82%. In Bangladesh CHWs bring to the table: Trust in the community users of service; timely and appropriate referral; equity; they bridge the gap between the system and those needing it; appreciation and retention by the community. Other neighbouring countries represented at the symposium seem to have also established CHW programmes including Nepal, Pakistan, Kenya, Uganda, India, etc, even though the most advanced is the Bangladesh example.

The side / parallel sessions comprised presentations from a very wide selection of country experiences (Kenya, DRC, Uganda, Nepal, India, Pakistan, Liberia, UK, France, etc) dealing with many aspects of the CHW initiatives. The HIFA Forum presentation was done by two HIFA members, Baba Aye and Polly Walker, and was very well received by the audience in the parallel session on Day 2.

The meeting recognised certain challenges with efforts to scale CHWs programme including: financing exponential increase in numbers of CHWs (even though it has been shown, not least in Bangladesh, that the programme is cost-effective); resistance to change from the present health system structure that excludes CHWs; etc.

At the side sessions that I attended I raised the fact of the information gap that exists when it comes to letting the world outside Bangladesh for instance hear the success of the policy of having the CHWs cadre and using them to spread inform and educate the users and that this is a role that HIFA online forum has as its vision. On every occasion/ session the message was well received. Hopefully with more awareness of HIFA created in Dhaka, the outcome from this symposium should include more new members joining the forum.

The Organisers of the 2nd Global CHW Symposium in Dhaka, Bangladesh from 22-24th November 2019 deserve a huge congratulation for the success due to the excellent planning and execution in all parameters of conference assessment. Particularly the flow of the over 600 participants from the plenaries to side sessions and back, and to many health breaks and refreshments was exemplary. Also worthy of high appreciation is the contribution and assistance by many Development partners and NGOs such as USAID, BMGF, WHO, UNICEF,

The take home message for all the countries, especially the LMICs must be that to achieve UHC and SDGs, they must establish a CHW programme without delay as the clock ticks towards 2030, and integrate it to their existing health system (usually primary, secondary and tertiary levels), and not as volunteers but as trained, supported, respected and appreciated health workers. There needs to be another level that is closer to communities (home clinics), the Community Health Worker Level (CHW) for all the many reasons that the symposium participants received, if they want to achieve UHC and SDGs. For those countries that already have a cadre called CHW for their PHC, they need to give these new level of workers another name, but they must be fully integrated into the health system as the first contact point for each community. Descriptions from this symposium, shows and it is obvious that this new cadre can be created without conflict of roles with any existing cadre, because they are primarily for promotion and prevention services at the home and family points.

8.2 David Musoke, Uganda

It was indeed a great symposium organised by icddr,b and partners in Bangladesh. The Community Health Workers' Thematic Working Group of Health Systems Global was pleased with the efforts of the organisers in making it a successful event.

Those interested in joining this group can send an email to the coordinator Faye Moody - Faye.Moody@lstmed.ac.uk

We are looking forward to receiving expressions of interest to host the 3rd symposium in 2021. The deadline for receiving applications is 31st January 2020.

<https://www.healthsystemsglobal.org/blog/377/Call-for-Expressions-of-Interest-to-host-3rd-International-Symposium-on-Community-Health-Workers-2021.html>

CITATIONS

Supportive supervision

Supportive supervision: Neglected Tropical Diseases in Nigeria

Moderator: Below are the citation and abstract of a new paper in Human Resources for Health. Financial and non-financial incentives, as well as supportive supervision, are emphasised. The authors do not comment on performance-based incentives. Citation, abstract and a comment from me below.

CITATION: Optimising the performance of frontline implementers engaged in the NTD programme in Nigeria: lessons for strengthening community health systems for universal health coverage

Akinola Oluwole, Laura Dean, Luret Lar, Kabiru Salami, Okefu Okoko, Sunday Isiyaku, Ruth Dixon, Elizabeth Elhassan, Elena Schmidt, Rachael Thomson, Sally Theobald & Kim Ozano

Human Resources for Health volume 17, Article number: 79 (2019)

<https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-019-0419-8>

ABSTRACT

Background: The control and elimination of Neglected Tropical Diseases (NTDs) is dependent on mass administration of medicines (MAM) in communities and schools by

community drug distributors (CDDs) who are supported and supervised by health facility staff (FLHF) and teachers. Understanding how to motivate, retain and optimise their performance is essential to ensure communities accept medicines. This study aimed to capture and translate knowledge, problems and solutions, identified by implementers, to enhance NTD programme delivery at the community level in Nigeria.

Methods: Qualitative data was collected through participatory stakeholder workshops organised around two themes: (i) identification of problems and (ii) finding solutions. Eighteen problem-focused workshops and 20 solution-focussed workshops were held with FLHF, CDDs and teachers in 12 purposively selected local government areas (LGA) across two states in Nigeria, Ogun and Kaduna States.

Result: The problems and solutions identified by frontline implementers were organised into three broad themes: technical support, social support and incentives. Areas identified for technical support included training, supervision, human resource management and workload, equipment and resources and timing of MAM implementation. Social support needs were for more equitable drug distributor selection processes, effective community sensitisation mechanisms and being associated with the health system. Incentives identified were both non-financial and financial including receiving positive community feedback and recognition and monetary remuneration. The results led to the development of the 'NTD frontline implementer's framework' which was adapted from the Community Health Worker (CHW) Generic Logic Model by Naimoli et al. (Hum Resour Health 12:56, 2014).

Conclusion: Maximising performance of frontline implementers is key to successful attainment of NTD goals and other health interventions. As NTDs are viewed as a 'litmus test' for universal health coverage, the lessons shared here could cut across programmes aiming to achieve equitable coverage. It is critical to strengthen the collaboration between health systems and communities so that together they can jointly provide the necessary support for frontline implementers to deliver health for all. This research presents additional evidence that involving frontline implementers in the planning and implementation of health interventions through regular feedback before, during and after implementation has the potential to strengthen health outcomes.

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Comment (NPW): There is clearly a huge amount of research on CHW programmes, with new studies emerging every week. The systematic reviews on which the CHW Guideline was produced appear to be based on research up to mid-2017. This raises the question (and challenge) of how best to use the CHW Guideline (published October 2018) while taking into account more recent findings. This kind of challenge is of course not unique to research on community health, but is perhaps especially important in this area. The CHW Guideline notes: 'the need and opportunity for a potential update will be considered five years after publication'.

Moderator: As Dr Tedros said in the introduction to the CHW Guideline: 'We know that having a competent, motivated and supported health workforce is the backbone of every health system.' The CHW Guideline refers to motivation repeatedly. 'To determine the best approach, it is important to understand both CHW and supervisor perspectives about the factors, financial or otherwise, that best motivate CHWs'

Citations: Supportive supervision and mHealth

Moderator: A new paper in PLoS Medicine. The authors conclude 'our data show that mHealth strategies can improve the coverage of proven MNCH services, especially in hard-to-reach populations, if there is adequate supportive supervision, change management, and ongoing technology assistance to ensure satisfactory adherence to the intervention'. I have invited the authors to join us.

CITATION: mHealth intervention "ImTeCHO" to improve delivery of maternal, neonatal, and child care services - A cluster-randomized trial in tribal areas of Gujarat, India

Dhiren Modi et al.

Published: October 24, 2019

<https://doi.org/10.1371/journal.pmed.1002939>

ABSTRACT

Background: The coverage of community-based maternal, neonatal, and child health (MNCH) services remains low, especially in hard-to-reach areas. We evaluated the effectiveness of a mobile-phone and web-based application, Innovative Mobile-phone Technology for Community Health Operations (ImTeCHO), as a job aid to the government's Accredited Social Health Activists (ASHAs) and Primary Health Center (PHC) staff to improve coverage of MNCH services in rural tribal communities of Gujarat, India.

Methods and findings: This open cluster-randomized trial was conducted in 22 PHCs in six tribal blocks of Bharuch and Narmada districts in India...

Conclusions: In this study, we found that use of ImTeCHO mobile- and web-based application as a job aid by government ASHAs and PHC staff improved coverage and quality of MNCH services in hard-to-reach areas. Supportive supervision, change management, and timely resolution of technology-related issues were critical implementation considerations to ensure adherence to the intervention.

Supportive supervision: Rwanda

Vincent Cubaka, Rwanda: Thank you for leading this important conversation and for sharing this list of research papers on supportive supervision of CHWs. A systematic review we published on supportive supervision of Primary Health care services in Sub Saharan Africa was not included in the list, yet we believe it contains knowledge that can also inform this conversation. Here is the link to the paper: <https://www.ncbi.nlm.nih.gov/pubmed/26653397>

[*Note from HIFA moderator (Neil PW): Thank you, Vincent Cubaka. For the benefit of those who may not have immediate web access, below are the citation and abstract. I note the full text is restricted access. Int J Gynaecol Obstet is Romeo Yellow journal (allows authors to archive pre-refereed fulltext).

CITATION: Int J Gynaecol Obstet. 2016 Jan;132(1):117-25. doi: 10.1016/j.ijgo.2015.10.004. Epub 2015 Nov 6.

A systematic review of supportive supervision as a strategy to improve primary healthcare services in Sub-Saharan Africa.

Bailey C1, Blake C2, Schriver M3, Cubaka VK4, Thomas T2, Martin Hilber A2.

Abstract

BACKGROUND: It may be assumed that supportive supervision effectively builds capacity, improves the quality of care provided by frontline health workers, and positively impacts clinical outcomes. Evidence on the role of supervision in Sub-Saharan Africa has been inconclusive, despite the critical need to maximize the workforce in low-resource settings.

OBJECTIVES: To review the published literature from Sub-Saharan Africa on the effects of supportive supervision on quality of care, and health worker motivation and performance.

SEARCH STRATEGY: A systematic review of seven databases of both qualitative and quantitative studies published in peer-reviewed journals.

SELECTION CRITERIA: Selected studies were based in primary healthcare settings in Sub-Saharan Africa and present primary data concerning supportive supervision.

DATA COLLECTION AND ANALYSIS: Thematic synthesis where data from the identified studies were grouped and interpreted according to prominent themes.

MAIN RESULTS: Supportive supervision can increase job satisfaction and health worker motivation. Evidence is mixed on whether this translates to increased clinical competence and there is little evidence of the effect on clinical outcomes.

CONCLUSIONS: Results highlight the lack of sound evidence on the effects of supportive supervision owing to limitations in research design and the complexity of evaluating such interventions. The approaches required a high level of external inputs, which challenge the sustainability of such models.]

Vincent Cubaka, Rwanda: I just realized that I forgot to share these two other studies that we did to explore supportive supervision of primary health care in Rwanda and that you could also consider including in the list.

Paper 1: <https://www.ncbi.nlm.nih.gov/pubmed/29462144> [*see note below]

Paper 2: <https://www.ncbi.nlm.nih.gov/pubmed/29113446>

Here are the citations for the above papers, both open-access:

1. PLoS One. 2018 Feb 20;13(2):e0189844. doi: 10.1371/journal.pone.0189844. eCollection 2018.

Perceptions on evaluative and formative functions of external supervision of Rwandan primary healthcare facilities: A qualitative study.

Schrivver M1,2, Cubaka VK1,3, Itangishaka S3, Nyirazinyoye L4, Kallestrup P1.

2. Afr J Prim Health Care Fam Med. 2017 Nov 1;9(1):e1-e11. doi: 10.4102/phcfm.v9i1.1508.

The relationship between primary healthcare providers and their external supervisors in Rwanda.

Schrivver M1, Cubaka VK, Nyirazinyoye L, Itangishaka S, Kallestrup P.

[Supportive supervision: Burkina Faso](#)

Moderator: This new paper in the November 2019 issue of the WHO Bulletin concludes: 'Supportive supervision cascades were critical in ensuring success.' It would be interesting to

see the guidance materials used for this process, especially those used at the community level (I was unable to find any).

CITATION: Task sharing for family planning services, Burkina Faso
Tieba Millogo, SÃ©ni Kouanda, Nguyen Toan Tran, BoezemwendÃ© KaborÃ©,
Namoudou Keita, Leopold Ouedraogo, Fatim Tall, James Kiarie, Nandita Thatte, Mario
Festin & Asa Cuzin-Kihl
WHO Bulletin 2019
<http://dx.doi.org/10.2471/BLT.19.230276>

ABSTRACT

Problem: In Burkina Faso, the coverage of services for family planning is low due to shortage of qualified health staff and limited access to services.

Approach: Following the launch of the Ouagadougou Partnership, an alliance to catalyse the expansion of family planning services, the health ministry created a consortium of family planning stakeholders in 2011. The consortium adopted a collaborative framework to implement a pilot project for task sharing in family planning at community and primary health-care centre levels in two rural districts. Stakeholders were responsible for their areas of expertise. These areas included advocacy; monitoring and evaluation; and capacity development of community health workers (CHWs) to offer oral and injectable contraceptives to new users and of auxiliary nurses and auxiliary midwives to provide implants and intrauterine devices. The health ministry implemented supportive supervision cascades involving relevant planning and service levels.

Local setting: In Burkina Faso, only 15% (2563/17 087) of married women used modern contraceptives in 2010.

Relevant changes: Adoption of new policies and clinical care standards expanded task sharing roles in family planning. The consortium trained a total of 79 CHWs and 124 auxiliary nurses and midwives. Between January 2017 and December 2018, CHWs provided injectables to 3698 new users, and auxiliary nurses or midwives provided 726 intrauterine devices and 2574 implants to new users. No safety issues were reported.

Lessons learnt: The pilot project was feasible and safe, however, financial constraints are hindering scale-up efforts. Supportive supervision cascades were critical in ensuring success.

SELECTED EXTRACT: 'The supportive supervision approach, combined with the engagement of the steering committee, was considered critical to ensure the success of the project as the supervision allowed a continuous and dynamic process of contribution, enrichment and nurturing among all consortium stakeholders, including the health ministry'

Citations: [Workload of CHWs](#)

'The female community health workers of India, known as Accredited Social Health Activists (ASHAs), form one of the largest community-based health workforce in the world.' This paper finds 'they are unrecognised and overburdened and aspire to be part of the health system'. Citation, abstract and a comment/request from me below.

CITATION: What do Accredited Social Health Activists need to provide comprehensive care that incorporates non-communicable diseases? Findings from a qualitative study in Andhra Pradesh, India. Marwa Abdel-All, Seye Abimbola, D. Praveen & Rohina Joshi
Human Resources for Health volume 17, Article number: 73 (2019)
<https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-019-0418-9>

ABSTRACT

Background: The Indian National Program for Cardiovascular Disease, Diabetes, Cancer and Stroke (NPCDCS) was introduced to provide non-communicable disease (NCD) care through primary healthcare teams including Accredited Social Health Activists (ASHAs). Since ASHAs are being deployed to provide NCD care on top of their regular work for the first time, there is a need to understand the current capacity and challenges faced by them.

Methods: A desktop review of NPCDCS and ASHA policy documents was conducted. This was followed by group discussions with ASHAs, in-depth interviews with their supervisors and medical officers and group discussions with community members in Guntur, Andhra Pradesh, India. The multi-stakeholder data were analysed for themes related to needs, capacity, and challenges of ASHAs in providing NCD services.

Results: This study identified three key themes — first, ASHAs are unrecognised as part of the formal NPCDCS service delivery team. Second, they are overburdened, since they deliver several NPCDCS activities without receiving training or remuneration. Third, they aspire to be formally recognised as employees of the health system. However, ASHAs are enthusiastic about the services they provide and remain an essential link between the health system and the community.

Conclusion: ASHAs play a key role in providing comprehensive and culturally appropriate care to communities; however, they are unrecognised and overburdened and aspire to be part of the health system. ASHAs have the potential to deliver a broad range of services, if supported by the health system appropriately.

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Comment (NPW): We have discussed previously on HIFA about the enormous expectations placed on CHWs (the 'key' to universal health coverage etc) and the increasing breadth of their responsibilities, without adequate support. The above paper is important because it gives a voice to ASHAs and shines a light on their perspectives and priorities. I look forward to hear of any other studies that give a voice to CHWs. We would be especially keen to have CHWs and ASHAs joining our discussion on HIFA directly. If you are in contact with ASHA or CHW group, please invite them to join us. There are literally hundreds of thousands of CHWs worldwide. Personally I believe they should have an opportunity to contribute.

Citations: [Scaling up CHW programmes](#)

Moderator: A new paper (published yesterday) in the open-access journal Human Resources for Health. It provides a case study on a national-level CHW programme and why it failed. 'The failure of the VHGScheme was a systemic one... The seeds of its downfall began with motives geared to gain quick political support for a newly elected government but without a sustained, long-term commitment. The problems began with the hasty planning of the scheme, which prioritized portraying the new government in a good light over ensuring that the structural elements of the program were sound...'

CITATION: The National Village Health Guide Scheme in India: lessons four decades later for community health worker programs today and tomorrow

Rachel J. Strodel & Henry B. Perry

Human Resources for Health volume 17, Article number: 76 (2019) | Download Citation
<https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-019-0413-1>

Abstract

Background: Based in part on the success of India's early community health worker (CHW) programs, the Government of India launched in 1977 a national CHW scheme—the Village Health Guides (VHGs)—to provide preventive, promotive, and basic curative care to rural populations. Although this program had promising origins in smaller demonstration projects, it failed to deliver the hoped-for impact at scale and was abandoned. Based on extensive evidence and experience, the World Health Organization and the World Health Assembly have strongly endorsed the value of national CHW programs and their integration into national health systems. Surprisingly, given the scale and importance of the VHG program and its pioneering nature as a national CHW program, little has been published describing this experience. This article is the second in a series that focuses on critical issues that face the effectiveness of large-scale CHW programs.

Case presentation: Several systemic factors emerge as main contributors to the failure of the VHG Scheme, namely, a lack of support from the formal health sector, an overly hasty implementation of the scheme, and poor communication between the government and health centers about the role of the VHGs. The remuneration structure and the VHG selection process were at the root of the program's shortcomings at the implementation level.

Conclusion: National CHW schemes are an increasingly important tool for achieving universal health coverage and ending maternal and child deaths by 2030. Although the VHG Scheme was initiated over 40 years ago, the lessons described in this case highlight important considerations to help both current and future large-scale CHW programs avoid the same pitfalls.

KEY MESSAGES

India's attempt to take to national scale a community health worker program based on several small-scale projects—such as the Comprehensive Rural Health Project at Jamkhed, Maharashtra—was a bold and visionary step to address unmet health needs in the country.

Unfortunately, little is known about the history of this program because it quietly disappeared. There is little documentation of the implementation of the program or evaluation of it after it was underway. This paper seeks to summarize the available information about this program.

The history of the Village Health Guide Scheme, along with substantial national experience since in India and beyond, points to the importance of careful planning by engaging health system actors at multiple levels, engaging the community, integrating the program with the health system, and obtaining buy in for long-term political and financial support to ensure sustainability and long-term effectiveness.

[Citations: CHWs and newborn care](#)

Moderator: The new print issue of The Lancet has an important paper with 'important public health implications. Our findings together with those from facility-initiated kangaroo mother

care trials provide conclusive evidence that kangaroo mother care, irrespective of the setting where it is initiated, has major benefits for the survival and growth of babies and infants with low birthweight. This finding implies that kangaroo mother care should be initiated for stable babies with low birthweight as soon as possible and should be given right through the neonatal period for as long as possible every day, as feasible'.

'The intervention delivery workers had 1012 years of school education, but no previous training in health care. Their educational background was similar to community health workers in India. Their supervisors were college graduates with no previous training in health care, similar to Accredited Social Health Activist (ASHA) supervisors (ie, government community health workers).'

Citation, summary and a comment from me below. Full text (free after one-time free registration) here: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)32223-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32223-8/fulltext)

CITATION: Effect of community-initiated kangaroo mother care on survival of infants with low birthweight: a randomised controlled trial

Sarmila Mazumder et al.

Published: October 04, 2019

DOI: [https://doi.org/10.1016/S0140-6736\(19\)32223-8](https://doi.org/10.1016/S0140-6736(19)32223-8)

SUMMARY

Background: Coverage of kangaroo mother care remains very low despite WHO recommendations for its use for babies with low birthweight in health facilities for over a decade. Initiating kangaroo mother care at the community level is a promising strategy to increase coverage. However, knowledge of the efficacy of community-initiated kangaroo mother care is still lacking. We aimed to assess the effect of community-initiated kangaroo mother care provided to babies weighing 1500-2500 g on neonatal and infant survival.

Methods: In this randomised controlled, superiority trial, undertaken in Haryana, India, we enrolled babies weighing 1500-2500 g at home within 72 h of birth, if not already initiated in kangaroo mother care, irrespective of place of birth (ie, home or health facility) and who were stable and feeding. The first eligible infants in households were randomly assigned (1:1) to the intervention (community-initiated kangaroo mother care) or control group...

Findings: Between July 30, 2015, and Oct 31, 2018, 8402 babies were enrolled, of whom 4480 were assigned to the intervention group and 3922 to the control group. Most births (6837 [81.4%]) occurred at a health facility, 36.2% (n=3045) had initiated breastfeeding within 1 h of birth, and infants were enrolled at an average of about 30 h (SD 17) of age. Vital status was known for 4470 infants in the intervention group and 3914 in the control group at age 28 days, and for 3653 in the intervention group and 3331 in the control group at age 180 days. Between enrolment and 28 days, 73 infants died in 4423 periods of 28 days in the intervention group and 90 deaths in 3859 periods of 28 days in the control group (hazard ratio [HR] 0.70, 95% CI 0.51-0.96; p=0.027). Between enrolment and 180 days, 158 infants died in 3965 periods of 180 days in the intervention group and 184 infants died in 3514 periods of 180 days in the control group (HR 0.75, 0.60-0.93; p=0.010). The risk ratios for death were almost the same as the HRs (28-day mortality 0.71, 95% CI 0.52-0.97; p=0.032; 180-day mortality 0.76, 0.60-0.95; p=0.017).

Interpretation: Community-initiated kangaroo mother care substantially improves newborn baby and infant survival. In low-income and middle-income countries, incorporation of kangaroo mother care for all infants with low birthweight, irrespective of place of birth, could substantially reduce neonatal and infant mortality.

Comment (Neil PW): This is yet another area where CHWs can be trained to deliver specific tasks. In our discussion on CHWs, we tend to talk about them in generalities and forget that (a) the number of potential tasks that could be undertaken by CHWs is far more than could ever be expected of one cadre, and (b) CHWs are in fact a highly heterogeneous group with diverse training needs. Many (an increasing percentage?) CHWs could be described as 'specialist CHWs', like the ones engaged in the above study. I am not sure we (or the CHW Guideline) have got to grips with this diversity and how to manage it. The Guideline notes that there can be no such thing as a universal curriculum, which had previously (and perhaps still is?) been promoted by many. Perhaps there is a case for a 'basic CHW training' followed by 'specialist CHW training'?

Citations: Selection criteria

This paper (below) notes: 'The WHO recommends using selection criteria based on education and personal attributes, and notes the importance of community engagement. However, the certainty of the evidence base used as part of the development of the WHO's recommendations was weak, and no specific selection methods were considered.'

Citation, abstract and comment from me below.

CITATION: Case study of a method of development of a selection process for community health workers in sub-Saharan Africa

Celia Brown, Richard Lilford, Frances Griffiths, Prince Opong-Darko, Myness Ndambo, Marion Okoh-Owusu & Emily Wroe

Human Resources for Health volume 17, Article number: 75 (2019)

<https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-019-0412-2>

ABSTRACT

Background: Choosing who should be recruited as a community health worker (CHW) is an important task, for their future performance partly depends on their ability to learn the required knowledge and skills, and their personal attributes. Developing a fair and effective selection process for CHWs is a challenging task, and reports of attempts to do so are rare. This paper describes a five-stage process of development and initial testing of a CHW selection process in two CHW programmes, one in Malawi and one in Ghana, highlighting the lessons learned at each stage and offering recommendations to other CHW programme providers seeking to develop their own selection processes.

Case presentation: The five stages of selection process development were as follows: (1) review an existing selection process, (2) conduct a job analysis, (3) elicit stakeholder opinions, (4) co-design the selection process and (5) test the selection process. Good practice in selection process development from the human resource literature and the principles of co-design were considered throughout. Validity, reliability, fairness, acceptability and feasibility—the determinants of selection process utility—were considered as appropriate during stages 1 to 4 and used to guide the testing in stage 5. The selection methods used by each local team were a written test and a short interview.

Conclusions: Working with stakeholders, including CHWs, helped to ensure the acceptability of the selection processes developed. Expectations of intensiveness — in particular the number of interviewers — needed to be managed as resources for selection are limited, and CHWs reported that any form of interview may be stressful. Testing highlighted the importance of piloting with CHWs to ensure clarity of wording of questions, interviewer training to maximise inter-rater reliability and the provision of guidance to applicants in advance of any selection events. Trade-offs between the different components of selection process utility are also likely to be required. Further refinements and evaluation of predictive validity (i.e. a sixth stage of development) would be recommended before roll-out.

Citations: Remuneration

Hermen Ormel, Maryse Kok, Sumit Kane, Rukhsana Ahmed, Kingsley Chikaphupha, Sabina Faiz Rashid, Daniel Gemechu, Lilian Otiso, Mohsin Sidat, Sally Theobald, Miriam Taegtmeier and Korrie de Koning (2019) Salaried and voluntary community health workers: exploring how incentives and expectation gaps influence motivation, *Human Resources for Health* volume 17, Article number: 59

<http://reachoutconsortium.org/learn-more/publications/salaried-voluntary-community-health-workers-incentives-expectation-motivation/>

Karuga RN, Mireku M, Muturi N, McCollum R, Vallieres F, Kumar M, Taegtmeier M and Otiso L (2019) Supportive supervision of close-to-community providers of health care: Findings from action research conducted in two counties in Kenya, *PLoS ONE* 14(5): e0216444

<http://reachoutconsortium.org/learn-more/publications/supportive-supervision-of-close-to-community-providers-of-health-care-findings-from-action-research-conducted-in-two-counties-in-kenya/>

Moderator: Thank you so much for sharing the two recent papers from the REACHOUT project. ('The REACHOUT programme is an ambitious international research project helping to understand and develop the role of close-to-community providers of health care in preventing, diagnosing, and treating major illnesses and health conditions in rural and urban areas in Africa and Asia.')

The first paper is especially relevant to our current discussion on remuneration of CHWs:

Hermen Ormel, Maryse Kok, Sumit Kane, Rukhsana Ahmed, Kingsley Chikaphupha, Sabina Faiz Rashid, Daniel Gemechu, Lilian Otiso, Mohsin Sidat, Sally Theobald, Miriam Taegtmeier and Korrie de Koning (2019) Salaried and voluntary community health workers: exploring how incentives and expectation gaps influence motivation, *Human Resources for Health* volume 17, Article number: 59

<http://reachoutconsortium.org/learn-more/publications/salaried-voluntary-community-health-workers-incentives-expectation-motivation/>

The summary includes some valuable comments:

'The recent publication of the WHO guideline on support to optimise community health worker (CHW) programmes illustrates the renewed attention for the need to strengthen the performance of CHWs. Performance partly depends on motivation, which in turn is

influenced by incentives. This paper aims to critically analyse the use of incentives and their link with improving CHW motivation.

'We undertook a comparative analysis on the linkages between incentives and motivation based on existing datasets of qualitative studies in six countries. These studies had used a conceptual framework on factors influencing CHW performance, where motivational factors were defined as financial, material, non-material and intrinsic and had undertaken semi-structured interviews and focus group discussions with CHWs, supervisors, health managers and selected community members.

'We found that (a mix of) incentives influence motivation in a similar and sometimes different way across contexts. The mode of CHW engagement (employed vs. volunteering) influenced how various forms of incentives affect each other as well as motivation. Motivation was negatively influenced by incentive-related "expectation gaps", including lower than expected financial incentives, later than expected payments, fewer than expected material incentives and job enablers, and unequally distributed incentives across groups of CHWs. Furthermore, we found that incentives could cause friction for the interface role of CHWs between communities and the health sector.

'Whether CHWs are employed or engaged as volunteers has implications for the way incentives influence motivation. Intrinsic motivational factors are important to and experienced by both types of CHWs, yet for many salaried CHWs, they do not compensate for the demotivation derived from the perceived low level of financial reward. Overall, introducing and/or sustaining a form of financial incentive seems key towards strengthening CHW motivation. Adequate expectation management regarding financial and material incentives is essential to prevent frustration about expectation gaps or "broken promises", which negatively affect motivation. Consistently receiving the type and amount of incentives promised appears as important to sustain motivation as raising the absolute level of incentives.'

The full paper is available here: <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-019-0387-z>

Citations: Voices of CHWs

This new paper in Health Policy and Planning concludes: 'ASHAs were motivated by a sense of autonomy and self-empowerment; a sense of competence, connection and community service; satisfaction of basic financial needs; social recognition; and feedback and answerability.'

CITATION: 'Our village is dependent on us. That's why we can't leave our work'. Characterizing mechanisms of motivation to perform among Accredited Social Health Activists (ASHA) in Bihar

Syed S Wahid, Wolfgang Munar, Sharmila Das, Mahima Gupta, Gary L Darmstadt
Health Policy and Planning, <https://doi.org/10.1093/heapol/czz131>

Published: 31 October 2019

Correspondence: wolfgangmunar@gwu.edu

ABSTRACT: Community health workers (CHWs) play major roles in delivering primary healthcare services, linking communities to the formal health system and addressing the social determinants of health. Available evidence suggests that the performance of CHW

programmes in low- and middle-income countries can be influenced by context-dependent causal mechanisms such as motivation to perform. There are gaps regarding what these mechanisms are, and what their contribution is to CHW performance. We used a theory-driven case study to characterize motivational mechanisms among Accredited Social Health Activists (ASHAs) in Bihar, India. Data were collected through semi-structured interviews with CHWs and focus group discussions with beneficiary women. Data were coded using a combined deductive and inductive approach. We found that ASHAs were motivated by a sense of autonomy and self-empowerment; a sense of competence, connection and community service; satisfaction of basic financial needs; social recognition; and feedback and answerability. Findings highlight the potential of ASHAs' intrinsic motivation to increase their commitment to communities and identification with the health system and of programme implementation and management challenges as sources of work dissatisfaction. Efforts to nurture and sustain ASHAs' intrinsic motivation while addressing these challenges are necessary for improving the performance of Bihar's ASHA programme. Further research is needed to characterize the dynamic interactions between ASHAs' motivation, commitment, job satisfaction and overall performance; also, to understand how work motivation is sustained or lost through time. This can inform policy and managerial reforms to improve ASHA programme's performance.

Citations: [Community Health Research Round-up](#)

Madeleine Ballard, USA: Welcome to the latest edition of the Community Health Research Round-up!... As always, previous editions of the round-up are available in our archive <https://chwimpact.org/research-round-up>

[See full list of citations here: <http://www.hifa.org/dgroups-rss/chws-73-dhaka-chw-symposium-1-community-health-research-round>]

Citations: [Measuring performance](#)

CITATION: Smisha Agarwal, Pooja Sripad, Caroline Johnson, Karen Kirk, Ben Bellows, Joseph Ana, Vince Blaser, Meghan Bruce Kumar, Kathleen Buchholz, Alain Casseus, Nan ChenHannah, Sarah Faich Dini, Rachel Hoy Deussom, David Jacobstein, Richard Kintuet al. A conceptual framework for measuring community health workforce performance within primary health care systems. *Hum Resour Health* (2019) 17: 86. <https://doi.org/10.1186/s12960-019-0422-0>

ABSTRACT

Background: With the 40th anniversary of the Declaration of Alma-Ata, a global effort is underway to re-focus on strengthening primary health care systems, with emphasis on leveraging community health workers (CHWs) towards the goal of achieving universal health coverage for all. Institutionalizing effective, sustainable community health systems is currently limited by a lack of standard metrics for measuring CHW performance and the systems they work within. Developed through iterative consultations, supported by the Bill & Melinda Gates Foundation and in partnership with USAID and UNICEF, this paper details a framework, list of indicators, and measurement considerations for monitoring CHW performance in low- and middle-income countries.

Methods: A review of peer-reviewed articles, reports, and global data collection tools was conducted to identify key measurement domains in monitoring CHW performance. Three consultations were successively convened with global stakeholders, community health implementers, advocates, measurement experts, and Ministry of Health representatives using a modified Delphi approach to build consensus on priority indicators. During this process, a structured, web-based survey was administered to identify the importance and value of specific measurement domains, sub-domains, and indicators determined through the literature reviews and initial stakeholder consultations. Indicators with more than 75% support from participants were further refined with expert qualitative input.

Results: Twenty-one sub-domains for measurement were identified including measurement of incentives for CHWs, supervision and performance appraisal, data use, data reporting, service delivery, quality of services, CHW absenteeism and attrition, community use of services, experience of services, referral/counter-referral, credibility/trust, and programmatic costs. Forty-six indicators were agreed upon to measure the sub-domains. In the absence of complete population enumeration and digitized health information systems, the quality of metrics to monitor CHW programs is limited.

Conclusions: Better data collection approaches at the community level are needed to strengthen management of CHW programs and community health systems. The proposed list of metrics balances exhaustive and pragmatic measurement of CHW performance within primary healthcare systems. Adoption of the proposed framework and associated indicators by CHW program implementors may improve programmatic effectiveness, strengthen their accountability to national community health systems, drive programmatic quality improvement, and plausibly improve the impact of these programs.

PROFILES OF CONTRIBUTORS

Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers. <http://www.hifa.org/support/members/joseph-0> <http://www.hifa.org/people/steering-group>
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Takang Arrey is a state registered nurse specialised in community health care and passionate about the works of community health workers in Cameroon. Takang has carried out research on health system determinants and work performance of CHWs. arreytk T gmail.com

Madeleine Ballard holds a PhD in evaluation science (EBSI) from the University of Oxford as a Rhodes Scholar and was previously the founding Program Manager of Last Mile Health, a Liberian organisation that trains community health workers to provide primary care in remote villages. She is now the Strategic Advisor to CHW 15. [*Note from HIFA moderator (Neil PW): The preceding profile is from 2017 and I note that Madeleine is now the Executive Director for Community Health Impact Coalition <https://chwimpact.org/>]

Mohammad Ali Barzegar is an initiator of Primary Health Care in Iran since 1971, and Representative of People's Health Movement (PHM) Iran. His interest include 45 years of national & international experiences on PHC, Sustainable Development and Public Health. barzgar89 AT yahoo.com

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