



HIFA Thematic Discussion on Community Health Workers

Week 1 (of 6): 16-22 January 2017

Note: For background info see: <http://www.hifa.org/news/join-hifa-thematic-discussion-community-health-workers-starting-16-january-2017>

HIFA is grateful for sponsorship of this discussion from *The Lancet*, Reachout Project/Liverpool School of Tropical Medicine, World Vision International and USAID Assist Project.

Please find below a compilation of the first 43 messages in this discussion on CHWs.

With thanks to the following HIFA members who have shared their experience and expertise so far:

1. Alex Little (UK)
2. Alhassan Aliyu Gamagira (Nigeria)
3. Chandrakant R Revankar (USA)
4. David Musoke (Uganda) 2 messages
5. Dennis Odwe (Uganda)
6. Donna Bjerregaard (USA)
7. Elizabeth W Ridgway (USA)
8. Jenny Ure (UK)
9. Joseph Ana (Nigeria)
10. Judith Tchuenkam Sandrine Nem (Cameroon)
11. Kausar Skhan (Pakistan) 7
12. Kavita Bhatia (India) 5
13. Lucie Byrne-Davies (UK)
14. Margaret Nanteza Hasasha (Uganda)
15. Meghan Brucekumar (Kenya)
16. Miriam Taegtmeyer (UK)
17. Moderator (Neil PW) 6
18. Mohammad Ali Barzegar (Iran) 3
19. Ram Shrestha (USA)
20. Rosalind Steege (Ethiopia)
21. Sally Theobald (UK)
22. Sharon Bright (Uganda) 3
23. Sunanda K Reddy (India)
24. Thomas Matete (Kenya)

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] Community Health Workers: Dr Sonia Sachs at Oxford University

Dear HIFA colleagues,

I attended a seminar today led by Dr Sonia Sachs, director of the 1 Million Community Health Worker campaign and the Center for Sustainable Development, Earth Institute, Columbia University.

(Both are HIFA Supporting Organisations:

<http://www.hifa.org/support/supporting-organisations/one-million-community-health-workers-campaign-1mchw>

<http://www.hifa.org/support/supporting-organisations/earth-institute-program-health-systems-development-and-research>)

Dr Sachs' talk was titled 'Health systems in low income settings' and was organised by the University of Oxford.

She gave a wonderful overview of health systems strengthening at global, national and local level, drawing also from her experience with the Millennium Villages Programme.

She especially emphasised the importance of Community Health Workers and the urgency to empower CHWs by meeting their information and learning needs - particularly through smartphone technology and I look forward to discussing this further on HIFA over the coming weeks.

I have invited Dr Sachs (and indeed everyone present at the seminar) to join us for the HIFA thematic discussion starting this Monday 16th January. Have a great rest-of-weekend.

Best wishes, Neil

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HIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All - www.hifa.org) and current chair of the Dgroups Foundation (www.dgroups.info), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Subject: [hifa] CHWs (1) What are the needs and priorities of CHWs?

Dear HIFA colleagues,

This week we aim to understand the needs and priorities of Community Health Workers, from their perspective:

1. When listening to CHWs needs and priorities, what do they say is needed to enable them to do their work more effectively?

Personally, I think this is a very challenging question. Not least because CHWs are rarely given a voice.

A couple of months ago a series of CHW events was held in Vancouver, Canada, as part of the Global Symposium on Health Systems Research. One of the objectives was to give CHWs a voice. Were any HIFA members at the conference? Did you have the opportunity to listen to CHWs express their needs and priorities? If so, please do share your observations here on HIFA by sending an email to: hifa@dgroups.org

Also, if you are aware of any research that asks questions to CHWs about their work, please let us know. (I suspect such research is rare.)

Even better, if you are a CHW yourself, or a CHW trainer or programme manager, or researcher, please do send an email to: hifa@dgroups.org and tell us about your work. If you are in touch with a CHW, please invite him/her to join us: www.hifa.org/joinhifa

Best wishes, Neil

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From: "Thomas Matete, Kenya" <koumate@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (2) Who is a CHW? - Integrated community case management (iCCM) project for Malaria, Pneumonia and childhood diarrhoea

As a medical doctor, the following two photos I took with a colleague and one CHW while working with community health workers in a Malaria Consortium integrated community case management (iCCM) project for Malaria, Pneumonia and childhood diarrhoea supported by UNICEF defined a community health workers better for me than 1000 words.

A community health worker is a trained and properly supervised community member who understands the health needs of his/her community and works to;

- prevent communicable diseases
- manage non complicated cases of diarrhoea, malaria and pneumonia (if allowed by national policy)
- refer severe cases of disease early
- has a career growth path that does not lure him/her away from the health needs of community members.
- empower community members
- articulate the health needs of his/her community

From my interactions with community health workers, I learnt that I should not question mothers when they bring sick children late, but to question any system that fails them.

I thank Malaria Consortium for coming up with policies to improve the welfare and training of community health workers.

Thomas Matete,
HealthRight International

HIFA profile: Thomas Matete is a Medical Doctor with MV, Kenya. Professional interests: Relationship between health and development: Poverty and infectious diseases, affluence and obesity. koumate AT gmail.com

[*Note from HIFA moderator (Neil PW): HIFA does not carry attachments. I have uploaded the two photos to DropBox:

<https://www.dropbox.com/sh/hjousxlik6ukary/AADThWSeTzY2aAoq3OoIm49ua?dl=0>]

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (3) HEWs in Ethiopia and Indoor Residual Spraying

Dear HIFA colleagues,

The key message of this new paper is that indoor residual spraying to prevent malaria can be implemented more efficiently by CHWs than by district teams.

CITATION: Indoor Residual Spraying Delivery Models to Prevent Malaria: Comparison of Community- and District-Based Approaches in Ethiopia

Benjamin Johnsa, Yemane Yeebiyo Yihdegob, Lena Kolyadaa?, Dereje Dengelaa, Sheleme Chibsac, Gunawardena Dissanayakec, Kristen Georged, Hiwot Solomon Taffesee, Bradford Lucasa

Glob Health Sci Pract December 23, 2016 vol. 4 no. 4 p. 529-541

<http://www.ghspjournal.org/content/4/4/529.full>

KEY MESSAGE: Integrating indoor residual spraying into the institutionalized community-based health system in 5 districts was more efficient than the district-based model and did not compromise quality or compliance with environmental standards.

ABSTRACT

Background: Indoor residual spraying (IRS) for malaria prevention has traditionally been implemented in Ethiopia by the district health office with technical and operational inputs from regional, zonal, and central health offices. The United States President's Malaria Initiative (PMI) in collaboration with the Government of Ethiopia tested the effectiveness and efficiency of integrating IRS into the government-funded community-based rural health services program.

Methods: Between 2012 and 2014, PMI conducted a mixed-methods study in 11 districts of Oromia region to compare district-based IRS (DB IRS) and community-based IRS (CB IRS) models. In the DB IRS model, each district included 2 centrally located operational sites where spray teams camped during the IRS campaign and from which they traveled to the villages to conduct spraying. In the CB IRS model, spray team members were hired from the communities in which they operated, thus eliminating the need for transport and camping

facilities. The study team evaluated spray coverage, the quality of spraying, compliance with environmental and safety standards, and cost and performance efficiency.

Results: The average number of eligible structures found and sprayed in the CB IRS districts increased by 19.6% and 20.3%, respectively, between 2012 (before CB IRS) and 2013 (during CB IRS). Between 2013 and 2014, the numbers increased by about 14%. In contrast, in the DB IRS districts the number of eligible structures found increased by only 8.1% between 2012 and 2013 and by 0.4% between 2013 and 2014. The quality of CB IRS operations was good and comparable to that in the DB IRS model, according to wall bioassay tests. Some compliance issues in the first year of CB IRS implementation were corrected in the second year, bringing compliance up to the level of the DB IRS model. The CB IRS model had, on average, higher amortized costs per district than the DB IRS model but lower unit costs per structure sprayed and per person protected because the community-based model found and sprayed more structures.

Conclusion: Established community-based service delivery systems can be adapted to include a seasonal IRS campaign alongside the community-based health workers' routine activities to improve performance efficiency. Further modifications of the community-based IRS model may reduce the total cost of the intervention and increase its financial sustainability.

COMMENT (Neil PW):

Ethiopia has a well developed community-based care system with 34,000 paid health extension workers (HEWs). Incidentally, this is almost the same as the number of CHWs (35,000) supported by World Vision in Ethiopia. Below is a brief overview of the government programme.

'Ethiopia has been implementing community-based health services through its Health Extension Program (HEP) since 2005. The HEP is a government-funded health service delivery program that aims for universal coverage of primary health care and equitable access to health services. The program prioritizes prevention and control of communicable diseases and has shown remarkable achievements in the reduction of maternal and child mortality and in the number of communicable disease cases... To deliver these services, the HEP is expanding its health infrastructure and developing a cadre of paid health extension workers (HEWs) who provide the services to the communities. The HEWs are typically young women with a high school diploma, whom the Government of Ethiopia employs after they complete a 1-year HEP training course. The HEP deploys 2 HEWs in every village of about 5,000 residents. Currently, there are about 34,000 HEWs in 15,000 rural communities in Ethiopia.'

Best wishes, Neil

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From: "Ram Shrestha, USA" <rshrestha@urc-chs.com>

To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (4) Who is a CHW? (2)

Dear Neil,

This is a very relevant question to ask about Who is a CHW? . But at the same time I want add another question Who is CHV (Community Health Volunteer)?.

When I look at the functional roles of these two I see a lot of differences. For example;

1. Uganda: VHTs are volunteers; midwives, nurse, enrolled nurse etc are CHWs
2. Ethiopia; WDA are volunteers; HEWs are CHWs
3. Nepal : FCHVs are volunteers; VHWs, MCHWs are CHWs
4. Ghana: CHV are volunteers: midwives, nurse, enrolled nurses are CHWs
5. India: ASHAs are volunteers; Nurses are CHWs

Almost all countries have this structure i.e. CHWs are incharge of community health system (which a part of the formal system) and CHVs are volunteers to support them.

It is important to understand this. Because of the following reasons:

1. CHWs are salary paid formal health system workers; they have to follow government rules and regulations for their hours of work, salary, benefits, incentives etc.
2. CHWs are legally responsible for their health facility
3. Any change in their status has to go through the government system and there are p.
4. their motivation problem and issues are the same as clinicians or doctors this can be solved by changing the processes in government system; community can provide only some temporary solutions

Whereas Community Health Volunteers are selected by community and are part of the community. They are not formally linked with health facility. It is expected that they should get strong support from the community like bicycle, incentives, respect, tc. It is important to maintain CHVs motivation in order to reach vulnerable, underserved and hard to reach people. Their motivation is also important for home visits and support patients for self-management.

I hope the discussion of CHWs will keep this in mind and not lumped them together. Because only addressing CHWs problems, without addressing CHVs problems, will not fix the problem of coverage, follow-up, referral and equity at the community level.

Thank you very much.

Ram Shrestha, D.Sc. (hon.), MS, M.Sc.

HIFA profile: Ram Shrestha is a Senior Quality Improvement Advisor, Community Health and Nutrition, USAID Health Care Improvement Project, University Research Company, Bethesda, Maryland, USA. www.hciproject.org rshrestha AT urc-chs.com

From: "Neil Pakenham-Walsh" <neil@hifa.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>

Subject: [hifa] CHWs (5) Who is a CHW?

Dear HIFA colleagues,

When we announced this thematic discussion on CHWs a couple of weeks ago, HIFA member Joseph Ana (Nigeria) raised a critical point:

"Who is a CHW? To understand their needs/priorities, establish their roles / responsibilities, acknowledge their contribution to health care, and seek solutions to their challenges, we need to be sure that we are discussing the same cohort of health workers."

Indeed, there is no single agreed definition of CHW. The same term is applied to a very wide range of general and/or special skills, including prevention and/or treatment responsibilities. A 'CHW' in one country may be entirely different from a 'CHW' in another country, and there are hundreds of different terms used for different types of frontline health worker in different countries and different languages.

A definition we have on the HIFA website is: "The umbrella term 'Community Health Worker' embraces a variety of community health aides selected, trained and working in the communities from which they come" (WHO 2007). CHWs may be men or women, young or old, literate or illiterate, salaried or volunteer, full-time or part-time.
<http://www.hifa.org/projects/community-health-workers>

There are many others.

This heterogeneity has given rise to attempts to create a typology of CHWs. Perhaps the best known is that published by WHO and the Global Health Workforce Alliance in 2010:

Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems (see Table 1, page 32)
http://www.who.int/workforcealliance/knowledge/publications/CHW_FullReport_2010.pdf

The authors note: 'There is a wide range of different CHWs, performing an even wide range of tasks. A typology is therefore not easy. One simple distinction, however, is that between generalist and specialist CHWs like MNCH workers, nutrition workers, TB and HIV/AIDS workers etc.'

Their 'Core Typology' of CHWs classifies them according to a range of parameters (Recruitment, Educational criteria (at entry), Training content duration and role, Certification process, Monitoring and supervision, Volunteer / salaried, General or performance based incentives, Career pathway and development, and Referral system). However, the content against these parameters is questionable. For example, under Recruitment: 'Applicant must be 18-40 years old'. (suggesting erroneously that in no circumstances can one become a CHW over the age of 40)

If anyone has new insights into definitions and typology, please do share by emailing: hifa@dgroups.org

Best wishes, Neil

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From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (6) What are the needs and priorities of CHWs? (2)

Dear HIFA colleagues,

I would like to thank HIFA member David Musoke (Uganda) for sharing this systematic review from 2014. It is especially relevant to our Question 1 (What are the needs and priorities of CHWs?) because 83 of the 97 studies that were included in the review asked CHWs themselves for their perspectives.

CITATION: Which intervention design factors influence performance of community health workers in low- and middle-income countries?

A systematic review

Maryse C Kok, Marjolein Dieleman, Miriam Taegtmeier, Jacqueline EW Broerse, Sumit S Kane, Hermen Ormel, Mandy M Tijm1 and Korrie AM de Koning
Health Policy and Planning 2015;30:12071227
doi:10.1093/heapol/czu126

<http://heapol.oxfordjournals.org/content/early/2014/12/11/heapol.czu126> (open access)

KEY MESSAGES

1. A systematic review of 140 quantitative and qualitative studies identified factors related to the nature of tasks and time spent on delivery, human resource management, quality assurance, links with the community, links with the health system and resources and logistics having an influence on CHW performance.
2. Good performance was associated with intervention designs involving a mix of incentives, frequent supervision, continuous training, community involvement and strong co-ordination and communication between CHWs and health professionals, leading to increased credibility of CHWs.
3. When designing CHW programmes, policymakers should take into account factors that increased CHW performance in comparable settings, to maximize programme outcomes.

COMMENT (Neil PW)

How can these (and other) studies can be translated into improvements in policy and practice that will lead to empowerment of different cadres of CHWs in different countries? We would be especially interested to hear from HIFA members who are linked with the current WHO guideline development group for the emerging WHO international recommendations on CHWs (expected later this year).

Many thanks and best wishes, Neil

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HIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All - www.hifa.org) and current chair of the Dgroups Foundation (www.dgroups.info), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

From: "Kavita Bhatia, India" <kavbha@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (7) What are the needs and priorities of CHWs? (3) ASHAs on WhatsApp

Dear All,

I am a member of the HIFA Working Group for CHWs and based in India. There are two large scale government programs of CHWs in India. Going by David's article, Ashas are one cadre under the Asha program of the National Health Mission, running since 2005. The second cadre is that of Anganwadi workers under the Integrated Child Development Scheme, a program running since 1972. Since the advent of mobile phones, several of these workers use the free WhatsApp service to connect.

I have set up two WhatsApp groups for getting the voices of these two CHW cadres and their supervisors to the discussion. One group runs in Marathi and one in Hindi. The group moderator for both the groups is a Asha worker.

I will be translating the responses of the groups verbatim for the duration of this discussion. We have 30 members and more are expected.

Here are the first responses to the first question:

1. CHWs want the administration to improve the logistics and supplies of health programs.

"Reliable transportation is needed to escort expectant mothers for delivery. The primary health centres should have all instruments to carry out safe deliveries. For collecting blood samples we need regular provision. " (AA from Arunachal Pradesh)

"When pregnant women prefer private hospitals for getting delivered, it is better for the administration to take note of this and improve the government facilities." (M, from Kashmir)

"We now fill all the records online but since there are one/two computers in the PHC, it becomes very difficult. There should be a separate computer allocated to PHCs for our use to update records." (ANMs (nurses) and Block facilitators)

"We should get pre formatted and printed notebooks to complete the records at the village level. A regular supply of these is necessary" (Several CHWs)

"Give us complete and regularly replenished drug kits" (CHWs)

2. CHWs want ownership from the administration

"We need the health administration to treat us with courtesy" (CHWs)

"We want designated resting room at the Primary Health Centres and at hospitals"

Much more to come....

Regards,
Kavita

Kavita Bhatia, PhD
Independent researcher (India)
Owner and manager of e-repository Ashavani
<http://www.ashavani.org>

HIFA profile: Kavita Bhatia is an independent researcher in public health. She is based in India. She has considerable experience in the documentation and evaluation of community-based voluntary health care programs, particularly those involving community health workers. Since the past few years, she has been doing research, documentation and advocacy for women community health workers in large scale public health care programs. She is interested in the gender issues, rights and professional development of women health workers. She also runs an e-platform called Ashavani (<http://www.ashavani.org>). She is also a member of the HIFA Working Group on Community Health Workers: <http://www.hifa.org/projects/community-health-workers> Email address: kavbha AT gmail.com

From: "Kausar Skhan, Pakistan" <kausar.skhan@aku.edu>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (8) CHWs mobilising communities to address the social determinants of health

I think a fundamental question is: Are CHWs a means for fulfilling the objectives identified by a Dr/Nurse (health manager), or she can also be an end in herself, whereby she is able to mobilize communities to address the social determinants of health.

HIFA profile: Kausar Skhan is with the Community Health Sciences Dept of Aga Khan University, Karachi, Pakistan. kausar.skhan AT aku.edu

From: "Sharon Bright, Uganda" <amanyasharonb@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (9) What are the needs and priorities of CHWs? (3)

Hello Everyone,

I'm Sharon Bright, a CHW trainer from Uganda

From my interaction with CHWs, they have often requested for the following

- Gumboots and Umbrellas to aid their work in weather extreme seasons
- solar phone chargers to charge their phones that are used in health care reporting
- performance based Incentives which could be in-terms of money, T-shirts, bags, caps, e.t.c
- Regular supervision and community support from governing authority
- Liaison with Health center Authorities for smooth referrals and disease reporting
- Monthly refresher training
- support in-terms of Uniform, Signages, and other utilities needed to aid their work

regards,

Sharon Bright Amany
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HIFA profile: Sharon Bright Amany is a Community worker Health trainer at Living Goods LTD in Uganda. Professional interests: Training programs for community health workers, Management of CHW programs, and Impact analysis studies for CHW programs.
amanya.sharonb AT gmail.com

From: "Dennis Odwe, Uganda" <odwedennis@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (10) What are the needs and priorities of CHWs? (4)

I would like to add on the concerns raised by Sharon in Uganda regarding CHWs

Another need the expect to be catered for is monthly salary to enable them deliver work well, transport means in terms of bicycles to easily reach the villages.

Regards
Dennis Odwe

HIFA profile: Dennis Odwe is the Executive Director of AGHA-Uganda (Action Group for Health, Human Rights and HIV/AIDS). Odwedennis AT gmail.com

From: "Judith Tchukenkam Sandrine Nem, Cameroon"
<sandrine.nem@r4dinternational.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (11) What are the needs and priorities of CHWs? (5)

Hello All,

I am a community health officer at R4D

According to exchange with others on the field the CHW needs :

More collaboration with the health personnel because sometimes the relationship between the two is not very well

Valorization of their work (Invitation to health activities; Letter of encouragement;

Recognition by the authorities of the community; Offer certain health services for free)

Availability of basic and quality material for the ASC (telephone, bag, tool box, coat, umbrellas, communication credit...)

Frequent supervision workshops to better control the work of CHWs.

Best Regards

Sandrine Nem

Community Health Officer R4D

Tel: 696983446

HIFA profile: Judith Nem Tchuenkam Sandrine is a Community Health officer at R4D (Research for Development) in the Cameroon. Professional interests: Capacity building on the work of the CHW, Sharing experiences with other community members. sandrine.nem AT r4dinternational.org

From: "Chandrakant R Revankar, USA" <revankarc@gmail.com>

To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>

Subject: [hifa] CHWs (12) Experience of working with CHWs in India, Indonesia, Afghanistan, Micronesia, Ghana, Cote d'Ivoire, and SE Asia

Dear All,

I am trying to respond to the following issues raised the HIFA network based on my experience and observations since 1974 onwards.

I had opportunities to work with the Community Health workers (CHW) or frontline health workers (also paramedical workers/ multipurpose workers including community volunteers in different country situations) in India, Indonesia, Afghanistan, Micronesian islands, Ghana, Cote de Ivoire, and some of the countries of South-East Asia in the field of elimination/eradication of Neglected Tropical diseases.

My overall long term experience and observations indicated that these CHWs are the backbone of universal health coverage and achieving some of the Sustainable Development Goals by 2030. So far, they contributed significantly towards eradication/elimination of some of the communicable diseases and meeting MDG goals 2015.

In the background of cumulative observations, let me try to address the following questions.

1. When listening to CHWs needs and priorities, what do they say is needed to enable them to do their work more effectively?

CHWs need regular training/orientation, objective assessment of their work and guidance, appreciation, and incentives of some form (not cash) and a friendly environment. A constant

rapport with their immediate supervisors (should be guide rather than inspector) and feedback to improve the quality of work to meet the set objectives.

2. How are these needs being addressed? Where are the gaps?

Their needs are being addressed to the extent possible wherever possible by their supervisors/ authorities/stake holders. However, it depends on each country situation- how well health budget, targets, and priorities etc. On the top, wars, conflicts, natural and manmade disasters/ risks are other influencing factors while addressing the gaps.

The main gaps are lack of healthy working environment, appropriate retraining, guidance, positive feedback, and scope for voicing on a common plat form (eg. Participating in the conference/meeting). And of course, adequate salary/incentives to sustain their families.

In the absence of all these, there is a constant migration of trained manpower (CHWs and others) to seek better working opportunities thus allowing ongoing activities to suffer.

3. Are there enough and appropriate avenues for the voices of CHWs to be heard (by the relevant stakeholders / authorities

More opportunities/ avenues to express their voices towards achieving the set goals are needed.

4. What are the mental health and psychosocial needs of CHWs? How can these needs be better addressed?

Like any other individuals working in health field in different situations (especially in difficult/challenging), CHWs are at higher risk of mental pressure and fatigue. Several working environmental and their family environmental factors constantly affect their work-outputs. Regular counselling, group exercise and social get together may be needed to re-energize them and build their confidence and interest in the work.

5. Are we expecting too much of CHWs? Is there a risk of exploitation and/or burn-out? How can their workloads be better rationalised?

Since more and more communicable/infectious diseases are emerging in addition to a battery of ongoing communicable and non-communicable diseases as wells as ever growing targets/goals, assessment indicators and records and reports, the pressure on existing CHWs is increasing. The man-power development in terms of CHWs is not always proportionately increasing everywhere to meet the demands/challenges. At the grass route level, many disease activities are being integrated for which one health worker is responsible.

Workforce turnover is a continuous dynamic process for various reasons and manpower development in proportion to the demands should be planned and implemented by the national/local governments including non-governmental organizations if quality of health care delivery is sustained. Other-wise, risk of burnout cannot be ruled out.

6. How can we meet the information and learning needs of CHWs working in challenging conditions?

Though it is not simple and easy, efforts should be made to meet the learning needs using both manual and electronic systems. Ever increasing internet facilities, low cost-computers, mobile phones, and other electronic media (eg. TV,radio,Webinars etc) to reach CHWs working even in remote and challenging conditions should be used more and more.

Regards

Dr. C R Revankar,
Independent Consultant

HIFA profile: Chandrakant R Revankar is a medical doctor working in the field of Communicable disease control for more than 30 years. He is specially interested in Neglected Tropical Disease elimination/eradication and TB control through primary health care services. He has vast experience in public health programme planning and implementation, decentralised health system, primary health care, advocacy, operational research etc. As a freelance health consultant, currently he is providing his expert services to World Health Organization,international health agencies, NGOs, Community based health organizations, universities and medical professional bodies specially in developing countries (as and when called for). He is based in New Jersey,USA. revankarcr AT gmail.com

From: "Kausar Skhan, Pakistan" <kausar.skhan@aku.edu>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (13) Is there any example of CHWs mobilizing community to address social determinants of health?

Is there any example of CHWs mobilizing community to address any social determinants of health?

HIFA profile: Kausar Skhan is with the Community Health Sciences Dept of Aga Khan University, Karachi, Pakistan. kausar.skhan@aku.edu

From: "Alex Little, UK" <alex@digital-campus.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (14) What are the needs and priorities of CHWs? (6)
Career progression

Dear all,

To follow up on the conversations and messages already posted... I'd be interested to know if there was any specific knowledge/research on whether having a clear career development pathway to higher level positions was also a priority (or not) for CHWs? For example, for a CHW to eventually become a qualified nurse/midwife or CHW supervisor.

My personal opinion/thoughts are that given the jump between a CHW and (eg) nurse, it's difficult for CHWs with the ambitions to further their career to have the opportunity & resources to take time out to study for this progression. But having incremental steps/support and professional development opportunities/recognition in-between a CHW and nurse level would help to ease this.

I realise that this 'professionalisation' of CHWs (over and above being 'just' salaried MoH staff) is already beginning to happen in some countries, for example Ethiopia (which I'm most familiar with) where health extension workers (HEWs) have the opportunity now to move from the pre-service level training (and practicing as HEW) to having upgrade training (though not up to nurse level), which gives them an enhanced salary & position.

My feeling is that having a clear career development pathway (and especially in an incremental way) could help increase CHW retention, motivation and also engagement in training - provided the training is linked to and recognized as part of their professional development.

Also, to follow up Dr Ram Shrestha's message, are there similar desires/motivations for CHVs (/VCHWs) to become paid CHWs?

Anyway, just throwing another question into the mix for the discussions... and would welcome any thoughts on the above.

Cheers,
Alex

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From: "Sunanda Kolli Reddy, India" <write2sunanda@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (15) What are the needs and priorities of CHWs? (6)
ASHAs on WhatsApp (2)

Dear All,

We, at CARENIDHI, set up a whatsapp group of our community workers in the Early Child Care and Development project for reporting work and putting forth their suggestions for improvement in their Community based Rehabilitation work (Home management of children with special needs and work with Anganwadis to identify Children with disabilities) somewhat along the lines that Kavita has but at a very small scale (a few wards in NE Delhi). Kavita's mail has showed the tremendous potential this has in establishing a dialogue at grass roots level on Policy relevant issues that matter at the community level. I shall follow this up with some feedback from grassroots on issues raised in HIFA.

Best regards,
Sunanda K Reddy

HIFA profile: Sunanda Kolli Reddy is a Consultant in Early Childcare and Development & Health Promotion in the context of Disability in Development at the Centre for Applied Research and Education in Neurodevelopmental Impairments & Disability-related Health Initiatives, CARENIDHI, in India. Professional interests: Developmental Paediatrics, by training and professional experience, community studies, with focus on childhood

developmental disabilities, early intervention and health promotion in the context of disability in resource-poor community settings. write2sunanda AT gmail.com

From: "David Musoke, Uganda" <dmusoke@musph.ac.ug>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (16) What are the needs and priorities of CHWs? (7)
Recognition and empowerment of CHWs

Dear Sharon,

Your contribution is spot-on regarding the needs and priorities of CHWs in the Ugandan context. What I may add is that they have always also expressed the need to be recognised for the work that they do. This includes recognition from community members, local authorities and health practitioners. Recognition from community members is usually there. However, they are very keen to have local leaders recognise them for example during village meetings and give them the platform to pass on health information to members. They would also want to be recognised whenever they go to health facilities and preferably offered services promptly so they may return to the community and carry out their CHW roles.

Best wishes,
Dr. David Musoke

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HIFA profile: David Musoke is a Lecturer at the Makerere University School of Public Health, Uganda. Professional interests: Malaria prevention, community health workers, environmental health, public health, disadvantaged populations. He is a member of the HIFA working group on CHWs. <http://www.hifa.org/projects/community-health-workers> dmusoke AT musph.ac.ug

From: "Kausar Skhan, Pakistan" <kausar.skhan@aku.edu>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (17) What are the needs and priorities of CHWs? (8)
Recognition and empowerment of CHWs (2)

This provides an interesting entry point for empowerment of CHWs. Communication skills and assertiveness skills need to be introduced to them

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From: "Meghan Brucekumar, Kenya" <meghan.brucekumar@lstmed.ac.uk>

To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (18) Who is a CHW? (3)

In thinking about who is a CHW in relationship to their task, education, and professionalization, we worked with policymakers and UNICEF teams to look at what various cadres of CHWs do and how they are not one homogeneous group but rather a mix of typologies:

https://www.unicef.org/health/files/Access_to_healthcare_through_community_health_workers_in_East_and_Southern_Africa.pdf

Some excerpts from the executive summary:

In addition to a comprehensive literature review, the study used a cross-sectional survey with closed- and open-ended questions administered to UNICEF Country Offices and other key informants to investigate and map CHW characteristics and activities throughout the region. Responses were received from 20 of the 21 UNICEF Country Offices in the UNICEF East and Southern Africa region in May/June 2013. Data on 37 cadres from across the 20 countries made up of nearly 266,000 CHWs form the basis of this report. This report catalogues the types and characteristics of CHWs, their relationship to the broader health system, the health services they provide and geographic coverage of their work.

At the global level, CHWs have largely been considered to be a homogeneous class of healthcare worker. A more nuanced differentiation would be helpful to improve policy coordination, strategic planning and implementation of community-based health care. Based on results of the present survey, a post-hoc classification identified four distinct types of CHWs in ESAR countries:

Summary Table: CHW classification model [*see note below]

1. Case Manager
2. Community Liaison
3. Health Promoter
4. Traditional Birth Attendant (TBA)-plus

There was only one TBA-plus CHW cadre reported in this study. However, this may be due to the underreporting of traditional birth attendants, as these are often considered a separate class of healthcare worker rather than a subset of CHWs. Having TBAs engaged in a slightly broader range of reproductive health activities beyond maternal delivery (including family planning) is likely more widespread and would be a low-cost model for expanding CHW care given the high geographic coverage of TBAs in many countries.

In summary, this research documents that CHWs provide a variety of services with a broad range of potential tools. The report presents current training, responsibilities, and the scale of CHW programs in 20 ESAR countries. It also puts forward a potential CHW classification model to improve advocacy for and targeting of appropriate community health interventions (see Summary Table, Table 3 and Annex 5).

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>

Subject: [hifa] CHWs (19) Who is a CHW? (4) CHWs and basic literacy skills

We are having a parallel discussion on HIFA-Portuguese.

A HIFA-pt member in Brazil states:

"É importante ressaltar que a única exigência para a atuação do agente comunitário ser saber ler e escrever"

which translates to

"it is important to emphasize that the only requirement for the community agent is to be able to read and write"

Basic literacy is a prerequisite in Brazil.

Are there any CHW cadres in other countries that do not require basic literacy skills? I suspect not, in which case basic literacy skills could/should be included in definitions of CHWs?

Best wishes, Neil

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HIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All - www.hifa.org) and current chair of the Dgroups Foundation (www.dgroups.info), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

From: "Joseph Ana, Nigeria via Dgroups" <HIFA@dgroups.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (20) Who is a CHW? (5) CHEWs in Nigeria

Dear All,

Alhasan [Alhassan Aliyu Gamagira, Nigeria, 11 January] has made a useful contribution to this topic, but on reading his statement [see pre-16 January message below] that 'Lastly, it is to be reminded that, there is no cadre of CHW as Senior CHEWs, Senior CHEW is earned by promotion while in service', I thought I should draw readers attention to the content of the National Task Shifting policy of Nigeria on CHEWs [Community Health Extension Workers].

The policy, 'TASK-SHIFTING AND TASK-SHARING POLICY FOR ESSENTIAL HEALTH CARE SERVICES IN NIGERIA. FEDERAL MINISTRY OF HEALTH August 2014' is currently being implemented across the country. Below is an extract from its content, page 15-16:

The recommended definition, modified from the WHO's definition, states:

A skilled birth attendant is an accredited health professional such as a doctor, midwife, nurse or a community health worker (CHO and CHEW) who has been trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and the newborn. □

For this definition, the cadre referred to as community health workers (CHEWs) will be those who have undergone a 36-month course in a training institution approved by the Community Health Practitioners Registration Board of Nigeria (CHPRBN).

These exclude the Junior Community Health Extension Workers (JCHEWs). **These cadres under reference are also sometimes referred to as Senior CHEWs.** The curriculum of CHEWs currently covers 90 hours of didactic lectures and competency-based trainings. The goal of the reproductive health (RH) course is to equip the student with the knowledge and skills to provide reproductive health care. The objectives of the RH course are to understand:

- Anatomy and physiology of the male and female reproductive systems
- Concept of reproductive health and rights, including FP
- Process of pregnancy
- Management of labor according to acceptable standards
- Care of the mother and child during the puerperium
- HIV diagnosis and care for mothers and children
- Population dynamics and the benefits of FP
- Abortion and its possible complications
- Concept of infertility
- Menopause and andropause
- Concept of female genital mutilation (FGM)
- And recognize the high-risk pregnant woman for prompt referral □

Joseph Ana.

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HIFA profile: 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: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

From: "Mohammad Ali Barzegar, Iran via Dgroups" <HIFA@dgroups.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (21) What are the needs and priorities of CHWs? (9)

Dear colleagues,

I fully agree with the valuable post made by Dr. CR Revankar in connection with the needs and priorities of CHWs. I may add a CHW's need in regard to knowing the pattern of the formal and informal leadership of the community for mobilizing community to address the social determinants of health. Needless to say that the role of informal leadership is vital for community engagement while briefing formal leaders are useful for getting into the community. (green line)

Warmest regards. Dr. M.A. Barzegar.

HIFA profile: 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

From: "Donna Bjerregaard, USA" <dbjerregaard@initiativesinc.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (22) What are the needs and priorities of CHWs? (10)
Supervision of CHWs

Hi,

This is an interesting article I found on supervising CHWs in Tanzania that could help support the discussion. Initial experiences and innovations in supervising community health workers for maternal, newborn, and child health in Morogoro region, Tanzania [*see note below]

Supervision is meant to improve performance and motivation of CHWs, the Integrated MNCH Program in Morogoro region, Tanzania, implemented a CHW pilot with a cascade supervision model where facility health workers were trained in supportive supervision for volunteer CHWs, supported by regional and district staff, and with village leaders to further support CHWs.

Results show that CHWs value supervision and appreciate when supervisors visit them in their village. Village leaders and district staff are engaged and committed to supporting CHWs. Despite these successes, facility-based supervisors visit CHWs in their village an average of only once every 2.8 months, CHWs and supervisors still see supervision primarily as an opportunity to check reports, and meetings with district staff are infrequent and not well scheduled.

Conclusions: CHW Supervision could be strengthened by streamlining supervision protocols to focus less on report checking and more on problem solving and skills development. Facility health workers, may not be the best mentors for certain tasks. CHW supervision innovations, such as an enhanced role for community actors, may be more suitable to support CHWs engaged primarily in health promotion than scarce and over-worked facility health workers.

Comments from the field reveal positive and negative aspects:

“I am just happy about [being supervised] because when you meet with the supervisors you can be corrected or congratulated, so I am happy about it” □ (CHW, female, age 24)

#What I like is when I write a monthly report and get suggestions from [my supervisors]. They show me where I went wrong and how to correct it” □. (CHW, male, age 29)

[My supervisors] want to be sure if we really work or we just bring them reports. One can fabricate a report. That's why they come to the leaders to see and ask them if we visit our areas. (CHW, male, age 34)

We present our report to the supervisor at the center and the supervisor takes it back to the village leaders. The supervisor receives my report and my colleague's report and compiles them. After compilation, he sends the feedback to the village leadership. (CHW, male, age 29)

I take their problems because I am their supervisor, because I am close with the village executive office and the chair person. If it is something urgent that we cannot wait for the village meeting then I go direct to see the village leadership and tell them the problem. (Facility-based supervisor, male, age 49)

When I reached a certain family... I told them I am the community health worker, but they told me Mr. I don't have time for that, so I stopped and went to the leaders. They called the family and explained that when the CHW comes again to accept her/him. We went for the second time, they received me warmly, and we are going on well. (CHW, male, age 22)

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[*Note from HIFA moderator (Neil PW): Many thanks Donna. The full text of this paper (Robertson T et al 2014) is available here:
<https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-015-0010-x>]

From: "Margaret Nanteza Hasasha, Uganda via Dgroups" <HIFA@dgroups.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (23) What are the needs and priorities of CHWs? (11)
Recognition and empowerment of CHWs (3)

Dear Dr. David Musoke,

Am glad CHWs are among your interests. Yes, for a long time CHWs have needed to be recognised by Local authorities at both the lower and higher authorities, but I personally think this recognition should start with the ministry of health policy implementers and the skilled healthy providers at the primary health levels. Because these are the immediate supervisors.

However CHWs should have more than just knowing how to write and read. There is a remarkable difference between a CHW who has had some basic training with at least some basic training in public health and even a bit more knowledge with regard to primary health. I understand Uganda has changed from CHWs to VHTs [*], and these are the people who carry out most primary health light duties like mass immunisation, HIV/AIDS sensitization, family planning and door/door public health education. I hope you agree with me that more knowledge shall add value and quality service.

Kagombe Hasasha Njeru,
Buikwe District Uganda.

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[*Note from HIFA moderator (Neil PW): VHT = Village Health Team.]

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To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (24) What are the needs and priorities of CHWs? (12)
Recognition and empowerment of CHWs (4)

Dear David,

Thanks for the great contribution,

CHWs always want that kind of recognition from leaders.

What we have opted to do is to always invite village authorities, district political leaders as well as district health officials to be present on their graduation day.

This helps them gain recognition and introduction as health workers in the communities where they work.

HIFA profile: Sharon Bright Amany is a Community Health Worker trainer at Living Goods LTD in Uganda. Professional interests: Training programs for community health workers, Management of CHW programs, and Impact analysis studies for CHW programs. amanya.sharonb AT gmail.com

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To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (25) Is there any example of CHWs mobilizing community to address social determinants of health? (2)

Dear Neil, Kausar and HIFA colleagues,

The question raised by Kausar our knowledgeable colleague [Is there any example of CHWs mobilizing community to address social determinants of health?] is very important one and needs to be addressed tactfully. It seems to me that CHW could do both. In the technical area of health she/he should follow the procedure and tasks identified by her/his supervisors (Doctors/ Nurses), but in the cultural area of community mobilization and behavioral change of the community for betterment she could be an end herself. It should be emphasized here that the Doctors/ Nurses who will set the objectives for CHW must be community oriented and health minded rather than disease oriented.

I remember in early 1974 when Iranian PHC program began, CHW was recommending mother to breast fed her child, but physician in the health centers were advising to stop breast feeding and provide mother box of powder milk which was given him as free sample for advertisement by powder milk company. With many thanks to Kausar who knew the answer of the question, but wisely raised it for further discussion.

Kindest regards. Dr. M. A. Barzegar.

HIFA profile: 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

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (26) Is there any example of CHWs mobilizing community

to address social determinants of health? (3)

Dear HIFA colleagues,

Our sister forum HIFA-Portuguese is having a parallel discussion on CHWs in Portuguese speaking countries (Brazil, Mozambique, Angola, Guinea-Bissau, Sao Tome e Principe, Cape Verde, Timor Leste). You can join the discussion here: <http://www.hifa.org/forums/hifa-portuguese>

Here are two contributions, the first from Brazil and the second from Mozambique, that relate to Kausar Skhan's question "Is there any example of CHWs mobilizing community to address social determinants of health?"

1. Brazil: "O que se assiste no Brasil, infelizmente, é uma transformação do papel do agente comunitário de saúde, que muitas vezes tem se tornado, sobretudo, mero agente de interesses de líderes político-partidários locais... Ocorre que a municipalização da saúde, embora tenha inúmeros efeitos benéficos e positivos, muitas vezes dá margem a manipulações políticas locais, onde aqueles que têm algum poder acabam por utilizar o trabalho dos agentes comunitários de saúde em benefício de interesses que nada têm a ver com os da saúde ou da própria comunidade.

"What is happening in Brazil, unfortunately, is a transformation of the role of the community health agent, who has often become, in the main, merely an agent of interests of local political party leaders... It occurs that the municipalization of health, although it has many beneficial and positive effects, often gives rise to local political manipulation, where those who have some power end up using the work of community health agents to benefit interests that have nothing to do with Those of health or of the community itself.

2. Mozambique: "... Ativistas, pois estes a pesar de existirem muitos, as actividades destes deixam muito a desejar"

"... Activists, because these despite their large number, their activities leave much to be desired"

In theory, the role of CHWs in community mobilisation is vital, and we have seen for example how important it is to mobilise the community to build resilience against outbreaks of disease such as Zika. The role of CHWs in mobilising communities for action such as health education and environmental health measures (such as measures to reduce mosquito breeding) is also very clear. Further along the spectrum from practical mobilisation to social mobilisation is the role of CHWs in promoting awareness of the right to health and the right to receive the highest possible standard of health care. I suspect things become more challenging when CHWs are expected to advocate on social determinants of health. These are, by definition, highly political: 'The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.'

http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

Best wishes, Neil

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HIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All - www.hifa.org) and current chair of the Dgroups Foundation (www.dgroups.info), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

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Subject: [hifa] CHWs (27) Is there any example of CHWs mobilizing community to address social determinants of health? (4) Lifestyle determinants of health

Dear colleagues

In the UK we have an example of health trainers. These are community members who are trained to try to address lifestyle determinants of health using an evidence based approach. They are salaried. I don't know if anyone knows of any evidence for their efficacy on addressing behaviours and ultimately health outcomes?

Best wishes
Lucie

Lucie Byrne-Davis PhD CPsychol PFHEA

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To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (28) What are the needs and priorities of CHWs? (13)
ASHAs on WhatsApp (2)

Dear All,

Here are some more responses to the first question from the WhatsApp group of CHWs. (A small addition is needed to the heading of this thread. The group has not only Ashas, but also

their supervisors and another cadre of CHWs in India called Anganwadi workers. We can call them CHWS and supervisors on WhatsApp.)

1. CHWs need recognition/ownership from the health system

" Any health providing organisation should function as cordially as a family where all have their place. There is a strong need for co-ordination between all the functionaries and us."
(CHW)

"There are different standards of treatment given to the permanent staff, the project staff and Ashas at the primary health centre. This mentality should be abolished. All should get similar respect" (CHW)

"Any task or new program that is announced, it is expected that we fall into line instantly."
(CHWs)

"It is true we have a dress code and I am glad we have a uniform, but if we miss out on informing even one child during the immunization drive, we are pulled up. But families do opt for private providers over the government services for treatment too. Have we the right to point that out to you?" (CHW)

2. CHWs need refresher courses and strong training programs

"During training, there should be proper division of the course work so that those who are not staying overnight, do not miss out on any content." (CHWs)

"We must be given regular training." (CHWs)

The most telling comment:

"We can share a lot of these observations at the primary health centre but our annual renewal of contracts will be endangered."

Kavita Bhatia, PhD

Independent researcher (India)

Owner and manager of e-repository Ashavani

<http://www.ashavani.org>

HIFA profile: Kavita Bhatia is an independent researcher in public health. She is based in India. She has considerable experience in the documentation and evaluation of community-based voluntary health care programs, particularly those involving community health workers. Since the past few years, she has been doing research, documentation and advocacy for women community health workers in large scale public health care programs. She is interested in the gender issues, rights and professional development of women health workers. She also runs an e-platform called Ashavani (<http://www.ashavani.org>). She is also a member of the HIFA Working Group on Community Health Workers: <http://www.hifa.org/projects/community-health-workers> Email address: kavbha AT gmail.com

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Subject: [hifa] CHWs (29) What are the needs and priorities of CHWs? (14)
ASHAs on WhatsApp (3) Remuneration of CHWs

Dear All,

The most number of WhatsApp messages were on the remuneration of Asha workers. Ashas only receive payment per task and not a salary. These payments are called incentives. Contrary to the normal understanding of incentive which indicates an amount IN ADDITION to a salary, incentives are the only payment for Ashas. There a mind boggling 40 tasks-60 tasks and no public access to the list. The tasks also keep changing and the Ashas find difficult to remember the incentives.

My take on this is that if a worker is designated as a volunteer and made to do so much for so less, it is institutionalized discrimination.

The major emergent themes were:

1. Ashas feel underpaid.
2. There are delays that further aggravate the situation.
3. There are several tasks that are not paid for. Many are due to the unofficial task shifting from the full time nurse (ANM) to the CHW ASHA.
4. There is a need for advance payment for travel. Ashas can claim after travel but many do not get reimbursed/do not know about it.
5. There is a uniform need for some fixed amount to be paid every month. Some states do give a fixed amount but there are no institutional strictures therefore the amount does not always reach the Ashas.
6. Ashas and Anganwadi workers are paying out of pocket for photocopying, travel and mobile phones. The same goes for the lower ranks of the full time health employees like facilitators/supervisors, ANMs and male multi-purpose workers.

"Please do not make Ashas do so many unpaid tasks, their morale gets shaken," (CHW)

Here is my article on this topic.

<http://www.epw.in/journal/2014/22/notes/performance-based-incentives-asha-scheme.html>

The full text can be seen in the Resources section of my website <http://www.ashavani.org>

Kavita Bhatia, PhD
Independent researcher (India)
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HIFA profile: Kavita Bhatia is an independent researcher in public health. She is based in India. She has considerable experience in the documentation and evaluation of community-based voluntary health care programs, particularly those involving community health workers. Since the past few years, she has been doing research, documentation and advocacy

for women community health workers in large scale public health care programs. She is interested in the gender issues, rights and professional development of women health workers. She also runs an e-platform called Ashavani (<http://www.ashavani.org>). She is also a member of the HIFA Working Group on Community Health Workers: <http://www.hifa.org/projects/community-health-workers> Email address: kavbha AT gmail.com

From: "Jenny Ure, UK" <urejenny@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (30) What are the needs and priorities of CHWs? (15)
Career progression (2) Recognition and empowerment of CHWs (5)

Think Alex makes a good point about bridging the training gap for CHWs so they have more of a career pathway - but also so they are recognised as practitioners on the ground, and can have more of a role at a local level. (Something that others in the this post have mentioned). Sometimes, also - having tangible links to others addressing similar issues successfully elsewhere can make all the difference. This is why we find MOOCs and other collaborative online support and recognition so important in key areas such as maternal and child health

Best Wishes
Dr Jenny Ure
<http://sostelemedicinacursos.ucv.ve/>

HIFA profile: Jenny Ure is a Research Fellow at Edinburgh University, UK. urejenny@gmail.com

From: "Alhassan Aliyu Gamagira, Nigeria" <algamagira@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (31) Who is a CHW? (6) Traditional healers

Dear All

Thanks to Ram Shretha for the 2 clarifications ie CHW as in charge of Community Health System (formal) and CHV as volunteer who support the CHW.

2 The above 2 Cadres of CHW remind me of the other cadre of Community (Traditional, Client PAID) Health Workers, who live in the community and are taking care of Clients with variety of ailments. These Cadre of CHWs acquire their knowledge, skills and expertise from their forefathers in the Family or Clan, they are well known, recognised, respected, believed and highly PATRONISED and PAID by Clients who patronise them (including the ORTHODOX Health Care Practitioners). These CHWs specialise in such Medical fields as; Obstetrics and Gynecology, Maternity Nursing, Psychiatry, Dentistry, Ophthalmology, ENT, Orthopaedics etc etc.

3 I wish to ask if these Cadres are part of this discussion on CHWs?

4 If so, which name or nomenclature shall we use to address them?

It is to be noted that in Nigeria and many other Countries in the world have these Cadres of CHWs and are well patronized and PAID for the services they render in both Urban and Rural Communities. Such cadres of CHWs publicly display their wares, expertise, miracles, capabilities and employ the services of some agents to attract Clients.

Thank you All

HIFA profile: Alhassan Aliyu Gamagira is a Chief Nurse Tutor (retired) with the Kaduna State MOH (now self employed), in Nigeria, and with professional interests in nursing, midwifery and public/community health. algamagira AT gmail.com

From: "Mohammad Ali Barzegar, Iran via Dgroups" <HIFA@dgroups.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (32) Is there any example of CHWs mobilizing community to address social determinants of health? (5)

Dear Neil,

In response to the question: is there any example of CHWs mobilizing community to address social determinants of health (SDOH)? I should say yes but with some clarification. To me the Basic Minimum Needs (BMNs), aiming to fight poverty and empower people for attainment of a better quality of life for the people, which have been initiated by WHO in Thailand under the Late Dr. Mahler leadership in 1974. The BMNs which have been replicated in some member states of WHO/ EMRO with special support of Ex EMRO Regional Director Dr. H.A. Gezairy, is similar to SDOH. The BMNs is considering the social and economic determinants of health which is identified by the people themselves. Therefore the people are deeply engaged in all phases of needs assessment, priority setting, planing, implementation and evaluation of the program, in which is missing in the most development program.

After this long clarification about SDOH and BMNs which are similar, I would like to answer the subjected question positively. Yes, there was some CHWs at least in three countries namely Somalia 1987-1991, Pakistan 1994- 2000, and Iran 2002-2004, where I personally was involved in BMNs program of the above mentioned countries. CHWs as a part of inter-sectorial team or BMNs team in collaboration with the members of the other 10-12 development sectors was an effective member of the team for preparation, sensitization, and mobilization of the community for meeting the basic needs (SDOH) of the people. Specially it was more visible and effective in Iran where CHWs were accepted as community leader for the long term dedicated and appreciative services to the community.

Thank you and warmest regards. Dr. M.A. Barzegar.

HIFA profile: 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

From: "Sally Theobald, UK" <Sally.theobald@lstm.ac.uk>
To: "HIFA - Healthcare Information For All" <HIFA@dggroups.org>
Subject: [hifa] CHWs (33) How to bridge community and health systems

Dear HIFA colleagues

I am enjoying the discussion, do read our editorial from 14 papers on Community health workers in different contexts published in Human Resources for Health: ~~â€œ~~Close-to-community providers of health care: increasing evidence of how to bridge community and health systems~~â€~~ [http://pubmed.ncbi.nlm.nih.gov/312960-016-0132-9](http://pubmed.ncbi.nlm.nih.gov/312960016-0132-9)

This outlines range of close to community providers including CTC providers are known by different names and titles in different contexts as well as synthesising findings on:

- Strategies to support CTC providers' interface role between communities and the health system
- The role of the community in the selection and support of CTC providers
- The need to move to supportive, structured relationships in CTC supervision
- The critical role of programme design, motivation and incentives in responsive and people-centred health systems
- Negotiating trusting relationships
- Power relationships and gender roles shape CTC interactions at multiple levels.

Many thanks
Sally

Prof. Sally Theobald
Professor in Social Science and International Health
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Proud hosts of HSG 2018

Support our partners and alumni saving lives in Yemen

<https://globalhealthsocialscience.tghn.org>

<http://www.buildingbackbetter.org/#overview>

REACHOUT linking communities and health systems

COUNTDOWN: Calling Time on Neglected Tropical Diseases

REBUILD: Research for stronger health systems post conflict

Research in Gender and Ethics: Building stronger health systems (RinGs)

PERFORM Improving health workforce performance

From: "Kausar Skhan, Pakistan" <kausar.skhan@aku.edu>

To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (34) Is there any example of CHWs mobilizing community to address social determinants of health? (6)

Dear All,

This discussion on CHWs and their role (are they lackeys or agents of social change) is extremely important. I have raised my concerns earlier, and have expanded my views in a small concept note, which I could share on this forum. (it was written for another forum)

I propose we examine the role of CHWs' in view of the variation in context in which they are to be found across the world. In Pakistan, and I assume many other countries, there is a situation which I would like to call: m: Where there is no State. By this I mean where the State does not demonstrate commitment to improving the life of the poor. This can be assessed with two parameters

- (a) Look at the allocation to health in the national budget.
- (b) How the private sector flourishes, and is unregulated.

Above are just two parameters. I am sure we could come up with more

Below are two diagrams to clarify what I am saying: The purport to examine the CHW roles in relation to the context in which they are working. [*see note below]

HIFA profile: Kausar Skhan is with the Community Health Sciences Dept of Aga Khan University, Karachi, Pakistan. kausar.skhan AT aku.edu

[*Note from HIFA moderator (Neil PW): HIFA does not carry graphics. I have uploaded the graphics to Dropbox here:
<https://www.dropbox.com/s/59mf87yes3jd18k/ksk%20CHW%20role%20%26%20their%20context.pdf?dl=0>]

From: "Miriam Taegtmeier, UK" <miriam.taegtmeier@lstmed.ac.uk>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (35) Who is a CHW? (7)

Standing et al. (2008) [*see note below] put forward a categorization of different types of CHWs, based on their roles. General CHWs execute shifted tasks in health prevention and curative care in a context of human resource shortage. Specialized CHWs focus on conditions that are of high prevalence or great public health need. Advocate or instructors are expert patient advocates or peer educators who empower those affected by various diseases to take responsibility for their own health. Facilitator CHWs are community mediators serving as local facilitators to enable people to develop solutions to problems, access resources, negotiate market alternatives and be aware of their rights. These different types of CHWs would require different selection and recruitment processes, incentives, training, supervision and supplies. More attention to the facilitator role is required if supportive supervision is to be effective in addressing the unique position of CHW between health systems and their communities and in order to enable community health workers to act as effective agents of social change.

Dr Miriam Taegtmeier

Reader

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[*Note from HIFA moderator (Neil PW): I did a google search and I think the paper to which Miriam refers is this: Standing, H., Mushtaque, A., & Chowdhury, R. (2008). Producing effective knowledge agents in a pluralistic environment: what future for community health workers? *Social Science & Medicine*, 66(10), 20962107. Below is the abstract. Regrettably the full text is restricted access, which clearly limits the usefulness of their proposed classification unless a freely accessible version is available somewhere?

ABSTRACT: 'This paper is concerned with how poor populations can obtain access to trusted, competent knowledge and services in increasingly pluralistic health systems where unregulated markets for health knowledge and services dominate. The term "unregulated" here derives from the literature on the development of markets in low income countries and refers to the lack of state enforcement of formal laws and regulations. We approach this question of access through the changing roles and fortunes of community health workers over the last few decades and ask what kind of role they can be expected to play in the future. Community based health agents have been used in many settings as a way of filling gaps in service provision where more skilled personnel are not available. They have also fulfilled a more transformative role in broad based community development. We explore the reasons for the decline of programmes from the 1980s onwards. Using the specific experience of Bangladesh, the paper considers what lessons can be learned from past successes and failures and what needs to change to meet the challenges of 21st century health systems. These challenges are those of establishing credibility and legitimacy in a pluralistic environment and creating a sustainable livelihood strategy. The article concludes with a discussion of four potential models of community based health agents which are not necessarily exclusive: a generic agent that is closely linked to a reputable supervisory agency; a specialist cadre working with particular health conditions; an expert advocate; and a mobiliser or facilitator who can mediate between users and health markets.'

From: "Kavita Bhatia, India" <kavbha@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (36) What are the needs and priorities of CHWs? (16)
Recognition and empowerment of CHWs (6)

Here are is a new article that corroborate that financial incentives, recognition and a stable health system are necessary for a successful CHW program. [*see note below]

Sustainability of performance based incentivized community health worker's model in high priority districts of Odisha, India

R Swain, P Panigrahi, M Som, A Dutta, KC Sahoo - International Journal of Scientific ?, 2017

Abstract: Mixed method approach was used to explore the sustainability of Accredited Social Health Activists (ASHAs) model in high priority districts of Odisha, India. A survey was conducted among 134 ASHAs followed by qualitative study among anganwadi workers auxiliary nurse midwives and non-governmental field coordinators. A conceptual framework was developed using grounded theory approach. The sustainability of ASHA model depended on the balance relationship between motivating and demotivating factors - the model may collapse if demotivating factors will be more than the motivating factors. In order to sustain the program, the demotivating factors should be minimized through eight mechanisms - incentive, insurance, free transport, recognition, role definition, training, hand holding support and supplies of logistics for sustainability of the ASHAs model. This study recommends the further research on policy or decision makers and program implementer's prospective towards ASHA model in India.

Thanks and regards,
Kavita

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Independent researcher (India)
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HIFA profile: Kavita Bhatia is an independent researcher in public health. She is based in India. She has considerable experience in the documentation and evaluation of community-based voluntary health care programs, particularly those involving community health workers. Since the past few years, she has been doing research, documentation and advocacy for women community health workers in large scale public health care programs. She is interested in the gender issues, rights and professional development of women health workers. She also runs an e-platform called Ashavani (<http://www.ashavani.org>). She is also a member of the HIFA Working Group on Community Health Workers: <http://www.hifa.org/projects/community-health-workers> Email address: kavbha AT gmail.com

[*Note from HIFA moderator (Neil PW): The full text is freely available here: <http://www.worldwidejournals.in/ojs/index.php/ijsr/article/view/13988/14107>]

From: "Rosalind Steege, Ethiopia" <rosalind.steege@lstmed.ac.uk>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (37) What are the needs and priorities of CHWs? (17)
mHealth and CHWs

Greetings!

My name is Rosie Steege I am a PhD student at LSTM working alongside the REACHOUT consortium. I am looking at close to community providers through a gender/equity lens.

I am currently based in Hawassa, Southern Ethiopia conducting fieldwork on an m-health project involving HEWs [*see note below]. I wish to understand how this technology can be used to facilitate stronger relationships with the health system and if there are positive or negative unintended consequences for the HEWs using this technology. The second stage of my research will take place in Mozambique where I am interested in exploring recruitment and retention strategies of APEs.

I am also conducting a CHW policy analysis and I am interested in understanding to what extend gender roles and relations are considered in policy development. For this, I am seeking participants to interview on this matter. If you have any experience that may be relevant then please feel free to get in touch at rosalind.steege@lstmed.ac.uk

Looking forward to connecting further.
Rosie

Rosalind Steege
Department of International Public Health
Liverpool School of Tropical Medicine
Pembroke Place, L3 5QA, Liverpool (United Kingdom)
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HIFA profile: Rosie Steege works at The Liverpool School of Tropical Medicine (LSTM), UK. [rosalind.steege AT liverpool.ac.uk](mailto:rosalind.steege@liverpool.ac.uk)

[*Note from HIFA moderator (Neil PW): In Ethiopia, Health Extension Workers are 'a female cadre of salaried community health workers (CHWs) [They] are secondary school graduates and receive a 1-year training in basic health service delivery. They are selected from the communities that they serve and are supposed to work at the health post level for 25% of their time and in the community for the remaining 75%. Over 38,000 HEWs are employed in Ethiopia'

A qualitative assessment of health extension workers' relationships with the community and health sector in Ethiopia: opportunities for enhancing maternal health performance.

Maryse C. KokEmail author, Aschenaki Z. Kea, Daniel G. Datiko, Jacqueline E.W. Broerse, Marjolein Dieleman, Miriam Taegtmeier and Olivia Tulloch. Human Resources for Health201513:80

<https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-015-0077-4> (open access)]

From: "Kausar Skhan, Pakistan" <kausar.skhan@aku.edu>
To: "HIFA - Healthcare Information For All" <HIFA@dggroups.org>
Subject: [hifa] CHWs (38) Who is a CHW? (8) Liberators or Lackeys?

I would like to share this brief outline on CHWs I have written for another network.

kausar

Community Health Workers Liberators or Lackeys? [1]

David Werner had raised this question in 1981, and today 16 years later, it is still valid. Community Health Workers can be paid workers or volunteers [2], and both situations have implications for strategies of supporting them, and articulating expectations from them. Under the leadership of Jack Bryant [3], Community Health Sciences Dept of Aga Khan University, two models of CHW were tested. One was called 'CHS led' model in which an honorarium was paid to the CHWs, and the other was Community led model where health volunteers worked with the PHC team. The striking feature of the latter was manifest in a question a health volunteer asked the community health nurse, 'why are you late today?'. The paid CHW, would never have the courage to ask such a question, and their subordination was embodied in their remark when at a meeting in the PHC center, they refused to sit on the chair of the field director of the PHC program. 'we can't sit on that chair', said one when she was being goaded to take the chair, looking at the large black, high back chair, leaning back, behind a desk. What is the source of power of a CHW, one could ask. What 'power' does a CHW have when she is subordinate to the PHC team, and undertake tasks determined by the PHC Team, compared to a CHW who derives her strength from the community to which she is accountable.

The trend in approach to CHW is more to seek improvement in her performance, and for fulfilling the task assigned to her. A systematic review of published articles on CHWs was said to provide following key messages:

1. A systematic review of 140 quantitative and qualitative studies identified factors related to the nature of tasks and time spent on delivery, human resource management, quality assurance, links with the community, links with the health system and resources and logistics having an influence on CHW performance.
2. Good performance was associated with intervention designs involving a mix of incentives, frequent supervision, continuous training, community involvement and strong co-ordination and communication between CHWs and health professionals, leading to increased credibility of CHWs.
3. When designing CHW programmes, policymakers should take into account factors that increased CHW performance in comparable settings, to maximize programme outcomes. [4]

As is quite apparent from the above points, CHWs is seen as a means for achieving some objectives, which are supposed to ensure health of the population being served. This is what makes them 'lackeys' (doing what has been assigned by somebody else), and not liberators, as Paulo Freire outlines liberation and liberators.

The notion of 'liberator' that is invoked in David Werner's article is well explained in Paulo Freire's thoughts and practices.

This person is not afraid to meet the people or to enter into a dialogue with them. This person does not consider himself or herself the proprietor of history or of all people, or the liberator of the oppressed; but he or she does commit himself or herself, within history, to fight at their side. — Paulo Freire, *Pedagogy of the Oppressed*

“Liberating education consists in acts of cognition, not transfers of information.” [5]

For a CHW to be a liberator means she is a critical thinker who recognized the structures of oppression which lead to poor health outcomes. In other words she would understand the importance of social determinants of health (SDH). She would be trained to reflect, analyze and facilitate the community to do the same, so that they could explore options for actions. In other words, the pedagogy used for CHWs would be critical. It would not only be based on scientific knowledge, but also on Freirean principles of education. (Education as liberation and not domestication.)

CONCLUSION

... the point is that if poor health is a political problem it will need a political not a technical solution. The answer is not more health care workers. The answer is health care workers who I. - can mobilize their own communities to improve their own health. Susan Rifkin [6]

There are many developing countries where the State commitment to the health of the poor is grossly inadequate. (Example Pakistan). Where there is no state, then other actors are needed both professionals, and the community (the oppressed groups specially). How CHWs become liberators means they can mobilize/engage/involve communities to address social determinants of health, and also hold the state accountable

Role of CHWs as leaders and not mere agents of health managers is the goal to promote and support.

1. David Werner had raised this issue in his article The Village Health Worker, Lackay or Liberator. 1981(http://www.fastonline.org/CD3WD_40/JF/JF_VE/SMALL/27-714.pdf)
2. CHWs are volunteers in Kenya and Iran, to name some countries . In Kenya, when I had an opportunity to meet some CHWs I was struck by the role of a church in creating economic opportunities for them.
3. Jack Bryant had led the US delegation to the Alma Ata meeting in 1978. He was a friend of Hafden Mahler and was instrumental in getting Mahler spend a week in the department of Community Health Sciences (CHS) of Aga Khan University (AKU), Karachi. He was committed to PHC which was integrated in the undergraduate medical education of AKU.
4. Shared in list serve of HIFA (health information for all) (HIFA@dgroups.org; on behalf of; Neil Pakenham-Walsh neil.pakenham-walsh@ghi-net.org. Jan 17, 2017)
5. Paulo Freire (https://www.goodreads.com/author/quotes/41108.Paulo_Freire)
6. Quoted in HEALTH PROMOTERS, POLITICAL STRUGGLE AND SOCIAL TRANSFORMATION , A Framework for Systematizing the Experience of a Popular Health Education Project in Chile A Master's Project Completed by Karen L. Anderson

HIFA profile: Kausar Skhan is with the Community Health Sciences Dept of Aga Khan University, Karachi, Pakistan. kausar.skhan AT aku.edu

From: "Sharon Bright Amany, Uganda" <amanya.sharonb@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (39) What methods work best for CHW training?

What methods work best for CHW training?

HIFA profile: Sharon Bright Amany is a health Trainer at Living Goods LTD, Uganda, a non-profit committed to improving community health through community health promoters that availing affordable health care services in rural communities. She trains community health promoters in key health topics including prevention and management of common childhood illnesses, newborn care, ECD and care for pregnant women. She also offers technical skills to CHW's on use of android phones for healthcare reporting. She has interest in maternal and child health, community-based health interventions, community health worker training, and management of CHW programs. amanyasharonb AT gmail.com

From: "Elizabeth W Ridgway, USA" <lisaridgway@mac.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (40) Is there any example of CHWs mobilizing community to address social determinants of health? (7)

Yes!! Today there are hundreds of thousands of people who work for the health of their communities (that makes them CHWs) and the women of the world, and they are marching in Washington and other cities around the planet. And what they want is access to health care and respect for their choices.

With respect,
Lisa Ridgway MD FAAP
Box 732
Wilson, WY 83014

HIFA profile: Elizabeth W Ridgway is a Pediatrician at Jackson Pediatrics in USA. Professional interests: Pediatric endocrinology, learning and behavioural problems, international pediatric care, family planning. lisaridgway AT mac.com _

From: "Kavita Bhatia, India" <kavbha@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (41) How to bridge community and health systems (2)
Power relationships and gender roles

This is with reference to the last point made by Sally "Power relationships and gender roles shape CTC interactions at multiple levels".

Kauser shares findings of similar power dynamics within the health care systems, but finds workers in Community-based organisations in a more powerful position than CHWs in structured government programs.

My own unpublished findings clearly showed gender and hierarchy as the defining factors for interactions in a structured government program - but it extended beyond CHWs, to the entire workforce. The largely male doctors were at the top but they had a pecking order too. And even male subordinates were subservient to superiors. Gender was an added dimension that affected interactions. Gender and power was at play in the community as well.

I suspect it might be the same in other countries.

We need hierarchy and gender sensitized sessions, programs and policies both within healthcare structures and the community.

We need CHW-sensitization sessions in health care structures and communities too for not many understand the CHW's role well.

From CHWs:

"Some in the community think we are out of our homes to make money"

"Some in the community make comments because we step out of the village at all hours for our work"

"I told my husband that you hack me to pieces if I am doing wrong, but no one should question me since I am not."

Kavita Bhatia, PhD
Independent researcher (India)
Owner and manager of e-repository Ashavani
<http://www.ashavani.org>

HIFA profile: Kavita Bhatia is an independent researcher in public health. She is based in India. She has considerable experience in the documentation and evaluation of community-based voluntary health care programs, particularly those involving community health workers. Since the past few years, she has been doing research, documentation and advocacy for women community health workers in large scale public health care programs. She is interested in the gender issues, rights and professional development of women health workers. She also runs an e-platform called Ashavani (<http://www.ashavani.org>). She is also a member of the HIFA Working Group on Community Health Workers: <http://www.hifa.org/projects/community-health-workers> Email address: kavbha AT gmail.com

From: "Kausar Skhan, Pakistan" <kausar.skhan@aku.edu>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (42) Power relationships and gender roles (2) Lady health workers in Pakistan

In Pakistan, we have LHW (lady health worker) in the govt system. They do what they are told to do and are not agents of social change as some Community development programs strive for. NGOs working on health issues and who have CHWs also have them fulfill pre assigned tasks. We need to look at the larger framework within which CHWs work. This framework does not address social determinants of health or challenge status quo or the state incompetencies.

HIFA profile: Kausar Skhan is with the Community Health Sciences Dept of Aga Khan University, Karachi, Pakistan. kausar.skhan AT aku.edu

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (43) Community Health Workers Help Fight Depression (2)

Dear HIFA colleagues,

Earlier this month we noted a news article, referring to HIFA member Vikram Patel:

'In India, the establishment of lay counselors was pioneered by psychiatrist Vikram Patel and colleagues at Sangath. The idea sprang from something Patel saw in Zimbabwe, where he worked as a psychiatrist in the mid-1990s. Community members were being trained to give care to people with AIDS. Patel figured that maybe the same approach could be used for people with mental illness...'

Full text: <http://n.pr/2jeUyLB>

I was therefore interested to see this new paper in JAMA describes current experience in Zimbabwe:

CITATION: Effect of a Primary CareBased Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe.

A Randomized Clinical Trial.

Dixon Chibanda, Helen A. Weiss, Ruth Verhey, Victoria Simms, Ronald Munjoma, Simbarashe Rusakaniko, Alfred Chingono, Epiphania Munetsi, Tarisai Bere, Ethel Manda, Melanie Abas, Ricardo Araya.

JAMA. 2016;316(24):2618-2626. doi:10.1001/jama.2016.19102

The abstract is available here:

<http://jamanetwork.com/journals/jama/article-abstract/2594719>

Regrettably the full text is restricted-access so we are unable to discuss it meaningfully here on HIFA. (With lead authorship from Zimbabwe this team would certainly have been able to publish in an open-access journal without cost.) I have invited the authors to join us to share their experience.

Best wishes, Neil

Let's build a future where people are no longer dying for lack of healthcare knowledge - Join HIFA: www.hifa.org

HIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All - www.hifa.org) and current chair of the Dgroups Foundation (www.dgroups.info), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org