



HIFA Thematic Discussion on Community Health Workers

Compilation of messages

Week 2: 22-29 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 second week of our discussion on CHWs.

Our thanks to the following HIFA members who shared their experience and expertise in the past week:

Abimbola Olaniran (UK)
Agoustou Gomis (Burundi)
Alhassan Aliyu Gamagira (Nigeria)
David Musoke (Uganda)
G Karanja (Kenya)
Jean Sack (USA)
Jenny Yamamoto (Japan)
Joseph Ana (Nigeria) 2 messages
Kausar Skhan (Pakistan) 2
Kavita Bhatia (India) 6
Maisam Najafizada (Canada) 2
Malcolm Brewster (UK)
Maryse Kok (Netherlands)
Moderator (Neil PW) 4
Mohammad Ali Barzegar (Iran)
Remi Akinmade (Nigeria)
Rosalind Steege (UK/Ethiopia) 2
Samuel Senfuka (Uganda)
Sharon Bright Amana (Uganda)

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>
To: "HIFA - Healthcare Information For All" HIFA@dggroups.org
Subject: [hifa] CHWs (44) What are the needs of CHWs? (18) Q2 How to meet the needs of CHWs?

Dear HIFA colleagues,

At the beginning of our discussion David Musoke shared this paper which 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;30:1207-1227
doi:10.1093/heapol/czu126
<http://heapol.oxfordjournals.org/content/early/2014/12/11/heapol.czu126> (open access)

I would like to ask if HIFA members can let us know about any other research (or other initiatives) that specifically ask CHWs for their perspectives on their work.

What do CHWs say is important to empower them to work more effectively? What are their needs and priorities?

And, moving into the second week of our discussion, we look at question 2:

Q2. How are these needs being addressed? Where are the gaps?

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: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>

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

Subject: [hifa] CHWs (45) Thank you for your contributions so far!

Dear HIFA colleagues,

Thank you to everyone for making this already such a rich and productive discussion!

Since we started on 16 January we have had 43 messages from 24 members in 10 countries:

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)

It is really tremendous to read your views. I am especially grateful to CHWs and CHW trainers for sharing your experience. Special thanks to Kavita Bhatia for setting up WhatsApp groups in India to enable ASHAs to share their views with us in their local language - amazing!

For the benefit of new members who joined us after 16th January, I have collated all 43 messages so far into a Word file and uploaded it to a DropBox folder. You can download it for reference here:

<https://www.dropbox.com/sh/cbzzvl3wkpp3w75/AADaUtqBr8ZgUYh5ICDDb5Qaa?dl=0>

In the same DropBox folder I have also collated 11 messages on CHWs that were sent between 5-15 January (ie before the official launch of the discussion).

Please keep your messages coming. This week we are looking especially at Question 2 Q2. How are the needs of CHWs being addressed? Where are the gaps?

Please feel free to contribute on any aspect of CHWs. Or simply send a self-introduction message about your work and interests. Just send an email to: hifa@dgroups.org

Do you know anyone who might be interested to join us? Forward this message and invite them to join here: www.hifa.org/joinhifa

Or point them to our landing page for info about the current discussion:

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

HIFA members have unique experience and knowledge which can help bring clarity to challenging questions. Key points of this discussion - your insights - will be presented at the Symposium on Community Health Workers, 21-23 February 2017, Kampala, Uganda.

<http://chwsymposium.musph.ac.ug/>

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.

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: "Remi Akinmade, Nigeria" <remi.akinmade@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (46) How to bridge community and health system (3)

Dear all,

I've been reading all contributions with keen interest. All has added to body of knowledge and also enrich my knowledge. However, I will like to share my humble experience empowering the community and Ward Health committee to strengthen the Health Systems. There are categories of Health Workers; Professional Health Workers who are in the Government or Private Health System and Volunteer Workers Workers who are members of community groups who volunteered to improve Community Health and Social Welfare, Health Systems and Services.

My observations shows there is poor access to the Health Services which may be due to cultural, financial and geographic gaps. Most Government and Private Health Systems are Health Facility Based. However, in the past the government health facilities especially at the Primary Health Care Services/Clinics conduct District Nursing Services and Home Visits including Domiciliary Services whereby delivery takes place in clients homes. Those health policies and services are non existent again. But international/national organizations are now working with government and CSOs to promote Health Systems Strengthening with community involvement thereby bridging gaps. Let me share our organization Community Health Information Education Forum (CHIEF) experience implementing such project:

<https://www.facebook.com/chiefngo/posts/1488597277836165>

HIFA profile: Remi Akinmade is Executive Director of Community Health Information Education Forum (CHIEF), Nigeria. Professional interests: Community Health, Primary Health Care, Maternal Neonatal Child Health (MNCH), Adolescent/Youth Health, STI/HIV/AIDS, Breast/Cervical Cancer, Advocacy, Rights of women, children, Capacity Building - training, empowerment programs, Male involvement. remi.akinmade AT chiefngo.org

From: "Jenny Yamamoto, Japan" <yamamoto.jenny@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (47) Q2 How to meet the needs of CHWs? (2) Transport and communication

Dear HIFA members,

Regarding the question of the needs of CHWs and how to meet them, I wanted to ask about transport related policies for CHWs. In several postings, we heard that transportation is a potential barrier in several respects:

1. When CHWs don't live close to the communities they oversee;
2. When they must accompany expectant mothers or sick members to health clinics (eg ASHAs reported by Kavita Bhatia);
3. To obtain the relevant materials and medicines to do their work.

In the ASHA program, I read that CHWs receive some compensation for transport costs. I also came across work done by World Bicycle Relief about how bicycles help broaden the area covered by health workers (<https://worldbicyclerelief.org/en/a-caregiver-conquers-distance/>). But I haven't come across many other government policies to address transport needs of CHWs.

In this regard, I would be grateful if anyone could share information on the following:

1. Government policies supporting the transport needs of health workers
2. Government policies which are giving CHWs mobile phones or other ICT technologies to help them reduce the time spent traveling to/from communities and thereby helping them to use their time more efficiently and reduce costs?

Thanks a lot,
Jenny

HIFA profile: Jenny Yamamoto is a Doctoral student at Hiroshima University, Japan. She previously worked on transport issues at the United Nations Economic and Social Commission for Asia and the Pacific, Bangkok. Currently, she is interested in mobility and access to health services in rural areas in both developed (Japan) and developing countries (South Asia). As part of her research, she will also consider the ways in which communication technologies and mapping of health information can contribute to better health outcomes. yamamoto.jenny AT gmail.com

From: "G Karanja, Kenya" <grace.gitonga@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (48) Q2 How to meet the needs of CHWs? (3) Protection against occupational hazards

Dear HIFA members,

Meeting community health workers needs is a complex issue and so I think it ought to be context specific. The basic requirements though, in my opinion need to be in place:

1. Mode of transportation
2. Tools of work depending on the kind work they are assigned including protective equipment
3. Some level of monetary incentive. For some CHWs, this is all the income they get especially in some places where the unemployment rates are very high. This also covers for some costs that sometimes incur while doing community health work e.g telephone calls

However, my question to the members is: how do we ensure that CHWs are adequately protected or covered against any form of occupational hazards. For example some CHWs

care for patients with infectious diseases like Tuberculosis and some transport biohazard material like sputum specimen etc. Also, considering these are not often on employment contract and so neither governments nor NGOs are liable to them.

Regards,

HIFA profile: G Karanja is a medical doctor at KAPTCO, Kenya. [grace.gitonga AT gmail.com](mailto:grace.gitonga@gmail.com)

From: "Kavita Bhatia, India" <kavbha@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (49) Q2 How to meet the needs of CHWs? (4) Transport and communication (2)

Dear Jenny,

India has dedicated ambulance services for transportation. There are dedicated hotline numbers so CHWs have to just dial the number to get an ambulance.

The gap is that sometimes the ambulances are not available. Second gap is that when patients are taken to health facilities during the regular working hours by bus/jeep, the travel money is at times not compensated. Third gap is that the Ashas themselves may not get the travel money for returning back from the health facility after dropping the expectant mother there.

These are gaps that can be easily addressed with better resolve and administration.

We do not have a facility to pay for mobile phones for any health functionary, another gap that can be easily addressed.

Can you share with us about the primary health care services in your country [Japan]?

Regards,

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](mailto:kavbha@gmail.com)

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>

To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (50) Q2 How to meet the needs of CHWs? (5) Every CHW should have a mobile phone preloaded with essential healthcare information

Dear Kavita,

First, thank you on behalf of us all for facilitating input from ASHAs in to this discussion. It is such a great idea to set up Whatsapp groups so that they can articulate their needs and priorities in the local language, for you to then pass this on to HIFA.

"We do not have a facility to pay for mobile phones for any health functionary, another gap that can be easily addressed."

I would be very interested to know more about what is being done to promote ownership of mobile phones for ASHAs and indeed for CHWs worldwide.

It seems the most basic tool for any ASHA/CHW.

I look forward to the day when every ASHA and every CHW will have essential healthcare information in their local language, at their fingertips to guide them in clinical decision making. Furthermore, resources such as the Red Cross First Aid App and Where There is No Doctor (to name just two) should be readily available on every mobile phone (not just for CHWs, although they are priority, but also for citizens).

Thousands of lives could be saved every day if every mobile phone had basic healthcare information, including and especially first aid, maternal, child health and nutrition information for citizens

For more information see the mHIFA Project: <http://www.hifa.org/projects/mobile-hifa-mhifa>

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: "Rosalind Steege, UK/Ethiopia" <rosalind.steege@lstmed.ac.uk>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (51) Transport and communication (3) Power relationships and gender roles (3)

Dear HIFA members,

I think the issue of transport is very relevant for CHWs, but we need to not only think about what is the best mode of transport in terms of cost, but what are the social and gender norms of that society. From my research I have seen how gendered the issue of mobility and transport is for CHWs across many contexts. In Afghanistan for example I was discussing with a colleague about why all the supervisors were male and the answer was lack of mobility - women are not free to travel to the health posts so cannot fulfil the supervisory role. Similar dynamics of restricted mobility are also seen in Pakistan. (Kavita, it would be great to hear experience from the ASHA programme in India on this).

Without real consideration of the context arranging suitable modes of transport may only benefit a portion of CHWs (male CHWs). An example of this comes from Northern Nigeria where motorbikes were distributed to male CHWs but not female CHWs as riding the bikes would expose their ankles. Advocacy is important here and these are the cultural contexts that also need to be explored and considered when making policy decisions about best modes of transport.

Regards,
Rosie

Rosalind Steege
Department of International Public Health |
Liverpool School of Tropical Medicine
Pembroke Place, L3 5QA, Liverpool (United Kingdom)
rosalind.steege@lstmed.ac.uk|

HIFA profile: Rosie Steege works at The Liverpool School of Tropical Medicine (LSTM), UK. rosalind.steege AT liverpool.ac.uk

From: "David Musoke, Uganda" <dmusoke@musph.ac.ug>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (52) Transport and communication (4) Protection against occupational hazards (2)

Dear Karanja and all,

You raise important concerns regarding transportation and personal protection equipment / wear for community health workers (CHWs). To share a bit of the Uganda experiences, some (but not all) of the CHWs were provided with bicycles many years ago by the Ministry of Health to support their transportation within their communities which were useful at the time. However, without much support for their maintenance, many of these did not last for a very long time.

Regarding protective wear, the CHWs are often provided with gloves to be used while carrying out rapid diagnostic tests (RDTs) in diagnosis of malaria under integrated community case management of childhood illnesses (iCCM). However, the gloves at times run out of stock and the CHWs are forced to work without them.

Best wishes,
Dr. David Musoke

Department of Disease Control and Environmental Health
School of Public Health
Makerere University College of Health Sciences
P. O. Box 7072, Kampala, Uganda
Email: dmusoke@musph.ac.ug ; sokidavi@yahoo.com
Mobile: +256712987736 ; +256704814265
<http://chwsymposium.musph.ac.ug/>

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: "Kavita Bhatia, India" <kavbha@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (53) Protection against occupational hazards (3)
Provision of free health care for CHWs

Dear G. Karanja,

It is a very important point that you have raised.

Let me share my findings of 2013 where Asha workers shared the very same concern with me - that we are often exposed to patients suffering from infectious diseases like TB and have no protection.

In the current Whats App group, this is what a Asha had to say.

"There is a program for women with low Hb. We too have the same. There should be something for us."

This is a gap that can be addressed by providing free preventive measures, medical treatment and insurance to all front line workers and their families. Indeed that should become mandatory for all working in the primary health care structure. I have read of cases where young doctors have lost their lives due to constant exposure to TB patients.

Physical safety is another hazard. There is literature that records threat to life to front line workers, although not in India.

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: "Sharon Bright Amana, Uganda" <amanyasharonb@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (54) Protection against occupational hazards (4)

The issue of occupational safety is important yet so challenging for health systems

In my opinion, CHWs who deal with such infectious diseases should;

Be availed with appropriate protective gear such as masks and gloves to minimize risk for infection spread

Should be regular trained and supervised to ensure safe use of he provided protective equipment

Should undergo regular medical examination such as weight monitoring to ensure that susceptible individuals are not exposed due to their nature of work

Group counseling and mentorship should be established to ensure the best possible mental well being

regards,

Sharon, Uganda

HIFA profile: Sharon Bright Amana 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 CHWs on use of android phones for hr 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: "Abimbola Olaniran, UK" <israelolaniran@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (55) How to bridge community and health system (4) CHW remuneration and motivation

Dear HIFA members,

Recently, I have been reading around CHW remuneration and motivation in general. While many of the key stakeholders in community health programmes agree that CHWs should be paid for the services they provide, there is less consensus on how and what they should be paid. A reflection on the various remuneration models (with their diverse pros and cons) left me with more questions than answers:

1. Salary or monthly allowance from the formal health system:

a. Will this be a threat to CHWs' commitment/allegiance to the community they serve? In practice, many paid CHWs seek to satisfy the system where their salaries/allowances come from rather than the community they are expected to serve.

b. Sustainability of this method of payment? Some stakeholders have suggested that community health programmes should seek to identify multiple funding sources for CHWs to ensure sustainability of funding. However, this may present with the challenge of multiple reports that CHWs may need to provide to each of the funders (sometimes amounting to burdensome duplication). Common purse and report for all funders? In view of the competition among some of these funders and the desire to attribute success to themselves alone.

c. How do we identify a salary scale for lay health workers with varied knowledge and skill levels? If we include educational level of candidates as selection criterion for lay health workers, many of the highly-motivated individuals may not qualify. Additionally, many communities may not have eligible candidates.

2. Team-based income generating activities:

a. For high performers, will they be motivated or demotivated by team-based reward considering that they may have put in more effort than other team members?

b. To what extent do these income-generating activities distract CHWs from the primary role of service delivery?

c. Sharing the dividends from the income-generating activity may be a source of conflict within the team with consequent impact on service delivery.

I acknowledge that solutions are sometimes context-specific but I would be very grateful for your kind opinions/ suggestions on the issues raised.

Many thanks in anticipation.

Abimbola Olaniran

HIFA profile: Abimbola Olaniran is a 3rd year Ph.D candidate at the Liverpool School of Tropical Medicine. His Ph.D titled, "Community health workers for maternal and newborn health: case studies from Africa and Asia" focuses on the challenges of CHWs in these countries. He is a member of the CHW thematic working group. israelolaniran AT gmail.com

From: "Samuel Senfuka, Uganda" <bsenfuka@gmail.com>

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

Subject: [hifa] CHWs (56) How to bridge community and health system (5) CHW remuneration and motivation (2)

Dear all,

My view which I have always shared with most of my comrades regarding remuneration of CHWs especially in Uganda is through community members' (households) monthly financial contribution. Community members can through collective discussions agree on an affordable monthly contribution which is specifically used to facilitate CHWs within their respective communities where CHWs serve.

This is possible, it's sustainable, community members will own CHWs and they will be able to hold them to account. Otherwise, I do not see our Govts especially in low income countries like Uganda sustaining payment of CHWs when in the first place many of them have failed to significantly motivate and retain the mainstream health work force.

In Uganda we had a similar mechanism of facilitating local defence units where each household in a designated local/urban council would contribute an agreed on monthly fee towards local defense services.

I think we can revisit such a financing mechanism to establish its efficacy.

Senfuka Samuel

HIFA profile: Samuel Senfuka is Project Officer with the Alliance Safe Motherhood, Uganda. bsenfuka AT gmail.com

From: "Joseph Ana, Nigeria via Dgroups" <HIFA@dgroups.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (57) Transport and communication (5) Power relationships and gender roles (4)

It was interesting to read Rosie's comment, that 'Without real consideration of the context arranging suitable modes of transport may only benefit a portion of CHWs (male CHWs). An example of this comes from Northern Nigeria where motorbikes were distributed to male CHWs but not female CHWs as riding the bikes would expose their ankles.'

We were not aware of this and it just goes to show that Learning Never Stops. It also reinforces our long held view that 'Context is everything' especially in Health.

I wonder what alternative mode of transportation in that terrain was provided for female CHWs.

Joseph Ana
Africa Center for Clin Gov Research & Patient Safety
@ HRI West Africa Group - HRI WAConsultants in Clinical Governance
Implementation/Publisher: Health and Medical Journals
8 Amaku Street Housing Estate,
Calabar
Cross River State, Nigeria

Phone No. +234 (0) 8063600642 Visit Website: www.hriwestafrica.com
E-mail: hriwestafrica@gmail.com

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: "Maryse Kok, Netherlands" <Maryse.Kok@kit.nl>
To: "HIFA - Healthcare Information For All" <HIFA@dggroups.org>
Subject: [hifa] CHWs (58) How to bridge community and health systems (6)

Health systems are complex, adaptive and social institutions, and this affirms the attention to the role of CHWs. They are not only part of the health workforce supporting the achievement of disease related targets, but they also have the potential to facilitate relationships between different actors in the health system, and act as social change agents by triggering the raising of voices of communities. In other words, CHWs play an important role in bonding, bridging and linking the pillars of social capital. However, as already stated by several HIFA members, it seems that CHWs' roles of facilitating social change and raising community voices have not been very prominent in CHW programmes over the past years. There is a need to look at how hard- and software elements in health systems and in community health programmes interact with each other. The software elements ideas, interests, relationships, power, norms and values of different actors are important as important as the hardware, when we would like to optimize the benefits of CHWs' unique interface role in health systems. For example, how can training or supervision interventions for CHWs be shaped in such a way that they trigger feelings of connectedness and serving the same goals, and create a sense of trust between various actors? Some observations with regard to these types of questions are addressed in the following paper:

<http://www.tandfonline.com/doi/full/10.1080/17441692.2016.1174722>

Kind regards,

Maryse Kok
Senior Advisor Health Systems

.....

<https://www.kit.nl/wp-content/uploads/2014/10/KIT-Health-Logo.png>

T +31205688388
<http://www.kit.nl/health>

P.O. Box 95001
1090 HA Amsterdam

Visitor address:
Mauritskade 63
1092 AD Amsterdam
The Netherlands

HIFA profile: Maryse Kok works in Research Health Systems at the Royal Tropical Institute in the Netherlands. Professional interests: Community health systems, Human resources for health, Sexual and reproductive health and rights. maryse.kok AT kit.nl

From: "Kausar Skhan, Pakistan" <kausar.skhan@aku.edu>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (59) Provision of free health care for CHWs (2) CHW remuneration and motivation (3)

What CHWs get is an important issue which does not get addressed. When the LHWs (equivalent to CHS) in Pakistan started agitating for regularization of their job, nobody supported them except some women rights group. It is interesting how all the health researchers who used LHWs did not come forward in their support. We need to talk of CHWs entitlements to health care for them and their families, pension, etc.

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

From: "Malcolm Brewster, UK via Dgroups" <HIFA@dgroups.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (60) Protection against occupational hazards (5)
Provision of free health care for CHWs (3)

I agree that this is an issue which requires attention.

The occupational health (OH) needs of health workers in LMICs are probably less well met than those in countries with better resources health services. In the case of workers, such as CHWs, who operate on the periphery of a health system, or are low in the health worker hierarchy, the resources devoted meeting their OH needs are likely to be particularly inadequate.

The OH needs of CHWs need to be addressed within the context of the wider health worker OH provision. Equitable provision for all health workers will promote cohesion between different cadres whilst unfair provision would reinforce divisions between them.

HIFA profile: Malcolm Brewster is a Community Nurse with the National Health Service, UK. Professional interests: Chronic disease, community nursing, medical anthropology, health care in Africa. He is a member of the HIFA Working Group on Information for Prescribers and Users of Medicines: <http://www.hifa.org/projects/prescribers-and-users-medicines> Email address: malcolmbrewster AT yahoo.com

From: "Rosalind Steege, UK/Ethiopia" <rosalind.steege@lstmed.ac.uk>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (61) Power relationships and gender roles (5) CHWs in northern Nigeria

Dear Joseph,

You are right - context is everything! Here is the paper the example came from, hope it is of interest to you: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4356278/>
[*see note below]

Regards,
Rosie

Rosalind Steege
Department of International Public Health |
Liverpool School of Tropical Medicine
Pembroke Place, L3 5QA, Liverpool (United Kingdom)
rosalind.steege@lstmed.ac.uk|

HIFA profile: Rosie Steege works at The Liverpool School of Tropical Medicine (LSTM), UK. rosalind.steege@liverpool.ac.uk

[*Note from HIFA moderator (Neil PW): For the benefit of those who may not have immediate web access, here are the citation and abstract:

CITATION: Female Health Workers at the Doorstep: A Pilot of Community-Based Maternal, Newborn, and Child Health Service Delivery in Northern Nigeria.
Charles A Uzundu, Henry V Doctor, Sally E Findley, Godwin Y Afenyadu, and Alastair Ager.
Glob Health Sci Pract. 2015 Mar; 3(1): 971088.

ABSTRACT

Introduction: Nigeria has one of the highest maternal mortality ratios in the world. Poor health outcomes are linked to weak health infrastructure, barriers to service access, and consequent low rates of service utilization. In the northern state of Jigawa, a pilot study was conducted to explore the feasibility of deploying resident female Community Health Extension Workers (CHEWs) to rural areas to provide essential maternal, newborn, and child health services.

Methods: Between February and August 2011, a quasi-experimental design compared service utilization in the pilot community of Kadawawa, which deployed female resident CHEWs to provide health post services, 24/7 emergency access, and home visits, with the control community of Kafin Baka. In addition, we analyzed data from the preceding year in Kadawawa, and also compared service utilization data in Kadawawa from 2008-2010 (before introduction of the pilot) with data from 2011-2013 (during and after the pilot) to gauge sustainability of the model.

Results: Following deployment of female CHEWs to Kadawawa in 2011, there was more than a 500% increase in rates of health post visits compared with 2010, from about 1.5

monthly visits per 100 population to about 8 monthly visits per 100. Health post visit rates were between 1.4 and 5.5 times higher in the intervention community than in the control community. Monthly antenatal care coverage in Kadawawa during the pilot period ranged from 11.9% to 21.3%, up from 0.9% to 5.8% in the preceding year. Coverage in Kafin Baka ranged from 0% to 3%. Facility-based deliveries by a skilled birth attendant more than doubled in Kadawawa compared with the preceding year (105 vs. 43 deliveries total, respectively). There was evidence of sustainability of these changes over the 2 subsequent years.

Conclusion: Community-based service delivery through a resident female community health worker can increase health service utilization in rural, hard-to-reach areas.]

From: "Kavita Bhatia, India" <kavbha@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (62) Transport and communication (6)

Dear Rosalind,

In India there is no such restriction of movement or mode of transportation. In fact some years back, there was a successful state level program where girls were given bikes in order to encourage them to reach their schools. However two wheelers would not really serve the purpose, since the CHWs move on their feet within their village and would need an ambulance or regular bus services to transport patients. For their own commute they use the public transport, buses or private share-a-seat jeeps. They often travel for hours to reach a health facility. The frequency and regularity of buses and the quality of roads can definitely be strengthened. Again, quite possible to achieve with resolve and investment.

I notice that this discussion has so far not included CHWs/front line workers from the West. Could we have them on board? They would perhaps also have less difficulty with the language.

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: "Kavita Bhatia, India" <kavbha@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (63) CHW remuneration and motivation (4)

Dear Kausar,

Anganwadi workers (CHWs since 1972) in India struggled for decades to get a basic pay. Asha workers (CHWs since 2005) are faced exactly with the same situation as you have described.

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: "Joseph Ana, Nigeria via Dgroups" <HIFA@dgroups.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (64) Power relationships and gender roles (6) CHWs in northern Nigeria (2)

I am grateful to Rosalind for sharing this article. And for Neil's useful accompanying comment.

I shall surely read the paper in full, particularly because health infrastructure in Nigeria is crying for serious investment even in the tertiary and secondary tiers of the sector. So, to read that the pilot was based on the least resourced facilities, called Health Posts, wets my appetite even more to see the details and lessons learned.

Joseph Ana.

Africa Center for Clin Gov Research & Patient Safety

@ HRI West Africa Group - HRI WA
Consultants in Clinical Governance Implementation
Publisher: Health and Medical Journals
8 Amaku Street Housing Estate, Calabar
Cross River State, Nigeria

Phone No. +234 (0) 8063600642
Visit Website: www.hriwestafrica.com
E-mail: hriwestafrica@gmail.com

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: "Kausar Skhan, Pakistan" <kausar.skhan@aku.edu>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (65) Lady health workers in Pakistan

LHWs [Lady Health Workers] have been absorbed in the health system. Their salaries are at times delayed. They have organized themselves and have office bearers. [*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](mailto:kausar.skhan@aku.edu)

[*Note from HIFA moderator (Neil PW): Thank you, Kausar. Do you have any thoughts on how we can hear directly from Lady Health Workers in Pakistan on this HIFA discussion? Do you know any office bearers who can speak on their behalf - either directly in English or in Urdu or Punjabi?]

From: "Maisam Najafizada, Canada" <mnajafizada@mun.ca>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (66) Transport and communication (7) Power relationships and gender roles (6) CHWs in Afghanistan

CHWs (66) Power relationships and gender roles (6) CHWs in Afghanistan

In Afghanistan, male CHWs can easily become Community Health Supervisors because they have the cultural advantage of being able to go around and riding a motorbike, while women remain in their positions as volunteer CHWs. I have conducted multiple fieldworks in rural Afghanistan and have visited many female CHWs with years of experience as birth attendants and CHWs, and who wished to become supervisors, but could not because they were not supposed to travel from village to village. It is a case of career development for CHWs. After many attempts, I found female supervisors - CHWS promoted to supervisors, who were walking long distances, doing their job more effectively compared to their male

counterparts, and changing social norms regarding mobility of women in their context. I suggest program implementers push for recruiting more female supervisors, which has multiple advantages.

Maisam

HIFA profile: Maisam Najafizada is an Assistant Professor at the Memorial University of Newfoundland in Canada. Professional interests: Human Resources for Health in resource-constraint settings, Health systems, social determinants of health. mnajafizada AT mun.ca ___

From: "Maisam Najafizada, Canada" <mnajafizada@mun.ca>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (67) NGOs providing healthcare in Afghanistan

Hello

I know an NGO (BARAN) that works in Bamyan, Afghanistan providing health care services in most remote areas of the country. Here is the details of the program manager of the NGO. [*see note below]

Dr. Hussain Ali Khalili | Provincial project Manager | BARAN (Bu Ali Rehabilitation and Aid Network) | Bamyan Sub Office | Skype: Hu_khalili
[Tel: + 93(0)77 45 88 818 | Email: Hussain.khalili@gmail.com |
Dr.H.khalili@baran.org.af | www.baran.org.af

Regards,
Maisam Najafizada

HIFA profile: Maisam Najafizada is an Assistant Professor at the Memorial University of Newfoundland in Canada. Professional interests: Human Resources for Health in resource-constraint settings, Health systems, social determinants of health. mnajafizada AT mun.ca

From: "Kavita Bhatia, India" <kavbha@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (68) Q2 How to meet the needs of CHWs? (6) ASHAs on WhatsApp (4)

I put the question 2 [*] on the Whats App groups and got several replies.

Needs being addressed: Anganwadi workers (trained CHWs in India taking care of children under 5 under a government program since 1972) are regularized to the extent that they have a basic monthly salary, and a largely defined work load and hours of work. So we have one Anganwadi worker, one helper and one Asha at the community level. Besides there are several layers of full time paid health personnel.

Gaps:

Here is what Anganwadi workers said about the gaps.

"A Anganwadi worker and helper currently work for a few hours daily. The children are supposed to come for their pre school and meal at 10 but come in at 11. Then how are we to provide all the services? We fall short of time to complete the home visits. Consider either fixed timings for the children or increase our working hours"

"A lot of the record keeping is allotted to us. This hinders us from reaching out to the community and the real services that we are supposed to give."

"Give us a computer in each village Anganwadi for accurate and swift record keeping"

Research findings about this program show that the other gaps are regular provisions, co-ordination between all the village level workers, lack of career opportunities and inadequate social security benefits.

Here is what the Ashas said about the gaps.

1. Strengthen the health services at the community level

"Improve the facilities at the Sub centre and Primary health centers so that more deliveries take place at that level and we do not refer to the hospital. Give better sanitation in all facilities and provision of hot meals for mothers who deliver"

"We should have more equipment at the primary health centre so that frequently used tests like sonography and x ray can be done there."

"Give us well equipped and regularly replenished drug kits"

2. Strengthen governance at the local level

"There is enough funding allotted for our expenses but since there is inadequate transparency we do not get our dues. Publicize what we can claim for"

"Display all responsibilities and do not make us do more than what is allotted to us"

"Co-ordinate supplies of ORS and other essentials with the programs so that we do not run short"

"When we bring an expectant mother to the primary health centre and then they are unable to do the delivery there, we take her to hospital. Should the ANM (full time nurse) not take charge and see that the mother is referred to the hospital? We are taking women for delivery to higher facilities on our own, whose responsibility is it if something goes wrong?"

"Ashas are not trained as doctors, yet we are the ones taking the expectant mother's primary responsibility to reach her to a hospital when she is due to deliver. If the primary health centre is unable to conduct the delivery then the medical officer or nurse should take charge and accompany"

"Do not make it compulsory for Asha to accompany a woman for her delivery at night."

"Plan your programs, supplies and required documentation with pre printed forms well in advance, so that we can implement well"

We have Asha facilitators (supervisors) on the group as well. They get a fixed amount every month. They asked for a computer for completing administrative duties and a designated work space.

3. Improve the attitude and behaviour of the full time health personnel

"The government health employees and authorities do not behave respectfully towards Ashas and their supervisors"

"The government health employees and authorities do not behave affectionately and do not convey a sense of ownership towards patients, therefore they avoid coming there. A lot of our energy goes towards convincing them otherwise/"

4. Reconsider allocation of incentives

"We are paid very low sums for some of the tasks and feel demoralized"

"Do not make Ashas do many unpaid tasks, it demoralizes them." This comment is made with reference to the unofficial task shifting that takes place at the local level, which is neither acknowledged nor paid for.

"Ashas need schemes to encourage them besides the money"

"Facilitators are either making village visits or filling forms and do not get a day off"

"Ashas are on duty every day of the week"

Since the internet connection was lost in some cases, Ashas are making Whats App calls to me. I will write in later. I am very grateful to them for their enthusiastic and optimistic response to HIFA. Let us ensure the best for our front line workers worldwide.

I would love to read about CHWs in Brazil, China, USA, Britain and the European countries.

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

[*Note from HIFA moderator (Neil PW):

Q1. When listening to CHWs needs and priorities, what do they say is needed to enable them to do their work more effectively?

Q2. How are these needs being addressed? Where are the gaps?

<http://www.hifa.org/news/join-hifa-thematic-discussion-community-health-workers-starting-16-january-2017>]

From: "Jean Sack, USA" <jean.sack@jhpiego.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (69) CHWs in the US and prevention of diabetes

CDC's MMWR [*] posted a link to the Community Preventive Services Task Force 2016 publication: Diabetes Prevention: Interventions engaging Community Health Workers : <https://www.thecommunityguide.org/sites/default/files/assets/Diabetes-Prevention-Community-Health-Workers.pdf>

Jean Sack

HIFA profile: Jean C Sack is a Public Health Informationist at Jhpiego - an affiliate of Johns Hopkins University, Baltimore, MD, USA. Jean.sack AT jhpiego.org

[*Note from HIFA moderator (Neil PW):

CDC = Centers for Disease Control (US)

MMWR = Morbidity and Mortality Weekly Report]

From: "Alhassan Aliyu Gamagira, Nigeria" <algamagira@gmail.com>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (70) Transport and communication (8) CHWs in northern Nigeria (3)

Good day to all,

Rosalind Steege UK/Ethiopia posting on CHW transport and gender roles (last paragraph) prompted me to ask the following questions:

- 1 Let us share that report from Northern Nigeria and its source.
- 2 Who and where are the motorbikes distributed to Male CHWs not the Females?
- 3 What happen when Female CHWs ankle is exposed?

Learning by experience, doing and participant observation are vital for human development.

I am from Northern Nigeria (NN), a trained and registered Nurse, Nurse Tutor, Public Health Nurse and Community Health Officer, worked at PHC, Secondary, Tertiary and Health care Training Institutions, State Ministries of Health and local Governments, Donor Agencies and Private Organizations in 13 out of the 19 states of Northern Nigeria in various capacities as a Teacher, Principal, Provost, Examiner to 3 National Bodies, Deputy Director and Director Primary Health Care overseeing PHC services of 13 Local Government Areas (225 Political

Wards) of Kaduna State, and currently a Chief Nurse Tutor, St Lukes Anglican Hospital Wusasa Zaria Northern Nigeria.

My knowledge of CHWs means of transport in NN are as follows;

- (a) a walk
- (b) Personal transport (manually or mechanically propelled)
- (c) Government, Donor Agency or Proprietor for dedicated service such as--(Bicycles, motorcycles, Saloon Cars, Panel Vans Pickup Vans, Buses, Jeep, Lorry).

Appropriate Human and Material resources are transported using the above means irrespective of gender.

It is to be noted that in NN, We strictly respect the tenets of our cultures/tradition and religions.

I cant remember seeing a Hausa Muslim Woman riding a bicycle/motorbike to whichever work she is engaged. Female Nursery, Primary and Secondary School Students (decently dressed) including my Children can be seen riding bicycle to School or around the quarters. I have seen female CHWs on bicycles and motorbikes with their ankles exposed in the Southern and Western towns of:

Enugu, Awka, Onitsha, Umuahia, Uyo, Portharcourt, Aba, Owerri, Nsuka, Benin, Agbor, Adoekiti, Ijebuode, Ibadan, Lagos, Badagry, Pakoto and many others.

In addition to transport other CHWs need are in the areas of;

2 provision of appropriate and functional equipment.

3 Continuing knowledge update

4 supportive Supervision

5 Quality service improvement using Peer Participatory Rapid Health Appraisal for Action (PPRHAA) and Client Oriented Provider Efficient (COPE) services.

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](mailto:algamagira@gmail.com)

From: "Kavita Bhatia, India" <kavbha@gmail.com>

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

Subject: [hifa] CHWs (71) Q1: What are the needs and priorities of CHWs? (19)

Research that asks questions to CHWs about their work

Dear Neil,

On 16th January you had put a question "if you are aware of any research that asks questions to CHWs about their work, please let us know."

I eagerly awaited other inputs before sharing my own work, but as you rightly pointed out, there is not much material of this nature. Here is my research report titled "Stakeholders' Engagements with the Community Health Worker: The Accredited Social Health Activist (ASHA)"

<http://www.esocialsciences.org/Articles/showArticle.aspx?qs=+30QEbn3Sin1XnvhkfnzXVMpYu7w83gG7XAQhjbRJx5JvXK7N5iWCi/2rwY2IAI+MuvqyRbuyIDZusDqUme4uA==>

"A key finding was the feeling of personal empowerment experienced by the ASHAs after joining this post despite the difficulties. The ASHA's personal empowerment from the work however did not translate to changes at home and at work in the face of the unequal power balances. The words of the ASHAs reflected a new reality where their gender was not a deterrent to their aspirations for space and growth. They were determined to work but their aspirations were not for a job in the government. Their overwhelming preference was for stability and improvement in their posts as Community Health Workers. They did not want to be employees. They preferred not to relinquish their pre-existent roles which they were currently powerless to give up."

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: "Agoustou Gomis, Burundi" <Agoustou_Gomis@wvi.org>

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

Subject: [hifa] CHWs (72) Q1: What are the needs and priorities of CHWs? (20)
CHWs feel isolated and unsupported

[The original message was in French (below). The following is a translation by me. Neil PW]

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

1.1 In most countries community health agents (which I feel is the term that best describes the English term CHW) feel alone and are tossed around by NGOs. They do not receive the supervision that the Ministry of Health personnel are responsible for providing and often the staff of NGOs visit or call them only to obtain data that are often questionable.

1.2 CHWs are often poorly equipped to accomplish correctly the delegated tasks which are increasing more and more, because of the failure of the health system, health staff concentrate in urban areas.

1.3 CHWs are the worst hit by failures in supplies and medicines for at least two reasons:

- a. Overall, the lack of achievement of targets by the reference centers which always command less than the needs
- b. Or simply, the chief nurse of the health post is not at all interested in the strategy
- c. Or the chief nurse of the health post is too busy.

1.4 The community must be better charged to take charge of the health of its population and the CHW will be only a link in the chain. In areas where there are successes, one often sees an efficient community participation that obliges the public sector health staff to better support the strategy...

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

1.1. Dans la plus part des pays les Acteurs de Santé Communautaire (de mon point de vue c'est le terme qui définit le mieux le vocable anglais : CHW) se sentent seuls et sont ballotés au gré des projets des ONG. Ils ne reçoivent pas la supervision que les Agents du Ministère de Santé sont en droit de leur fournir et souvent le Staff des ONG les visitent ou les appellent que pour extraire les données souvent douteuses.

1.2. Les Acteurs de Santé Communautaire (ASC) sont souvent mal équipés pour accomplir correctement les tâches d'activités qui augmentent de plus en plus à cause de la défaillance du système de Santé, le personnel de Santé se concentrant dans les grandes agglomérations.

1.3. Les Acteurs de Santé Communautaire (ASC) sont les plus frappés par les ruptures d'intrants et des médicaments traceurs pour au moins deux raisons :

- a. Globalement la non maîtrise de la cible par les centres de référence qui commandent toujours moins que les besoins
- b. Ou simplement, l'Infirmier Chef du Poste de Santé (ICP) de référence ne s'intéresse pas du tout à la stratégie
- c. Ou alors l'ICP est très chargé

1.4. La Communauté doit être mieux organisée pour la prise en charge de la Santé de sa population et l'ASC ne sera qu'un maillon de la chaîne. Dans les zones où il y a des réussites, on note souvent une participation communautaire efficace qui oblige les agents de Santé de l'Etat à mieux supporter la stratégie.....

Dr Ago

Dr Agoustou Gomis | Regional Health & Nutrition Advisor | WARO | www.wvi.org
 Cell Phone: (+221) 77 819 94 21 | Burundi: (+257) 72455642 | E-mail:
 agoustou_gomis@wvi.org

[Mailing: Sacre-Coeur 3 / VDN Villa No 145 M/S, Dakar, 3731 RP Senegal M/S [agogo1016@gmail.com, Skype: agoctave; Tweeter: @Agoctave], Dakar, 3731 RP Senegal]

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>
 To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
 Subject: [hifa] CHWs (73) Community Health Assistants in Zambia (1) Abstracts in restricted-access journals

Dear HIFA and HIFA-Zambia members,

I was interested to see this citation and abstract (thanks to John Eyers). The authors make 'recommendations for implementation and future scale'. Regrettably however, the full text is restricted-access so most of us will not know what those recommendations are.

(Comment: From my years of experience in identifying papers relevant to HIFA, I get the impression that abstracts of papers in restricted-access journals tend to be less informative - especially as regards conclusions and recommendations - than abstracts in open-access journals. It is as if the abstracts in restricted-access journals are being deliberately presented as an advertisement to persuade the reader to purchase the full text. If anyone on HIFA would like to test this hypothesis, please do - I would be very interested to see the results.)

CITATION: Shelley KD; Belete YW; Phiri SC; Musonda M; Kawesha EC; Muleya EM; Chibawe CP; van den Broek JW; Vosburg KB. Implementation of the Community Health Assistant (CHA) Cadre in Zambia: A Process Evaluation to Guide Future Scale-Up Decisions. *Journal of Community Health*. 41(2):398-408, 2016 Apr.

ABSTRACT

Universal health coverage requires an adequate health workforce, including community health workers (CHWs) to reach rural communities. To improve healthcare access in rural areas, in 2010 the Government of Zambia implemented a national CHW strategy that introduced a new cadre of healthcare workers called community health assistants (CHAs). After 1 year of training the pilot class of 307 CHAs deployed in September 2012. This paper presents findings from a process evaluation of the barriers and facilitators of implementation of the CHA pilot, along with how evidence was used to guide ongoing implementation and scale-up decisions.

Qualitative inquiry was used to assess implementation during the first 6 months of the program rollout, with 43 in-depth individual and 32 small group interviews across five respondent types: CHAs, supervisors, volunteer CHWs, community members, and district leadership. Potential 'implementation moderators' were explored using deductive coding and thematic analysis of participant perspectives on community acceptance of CHAs, supervision support mechanisms, and coordination with volunteer CHWs, and health system integration of a new cadre. Community acceptance of CHAs was generally high, but coordination between CHAs and existing volunteer CHWs presented some challenges. The supervision support system was found to be inconsistent, limiting assurance of consistent quality care delivered by CHAs. Underlying health system weaknesses regarding drug supply and salary payments furthermore hindered incorporation of a new cadre within the national health system. Recommendations for implementation and future scale based on the process evaluation findings are discussed.

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

From: "Mohammad Ali Barzegar, Iran via Dgroups" <HIFA@dgroups.org>
To: "HIFA - Healthcare Information For All" <HIFA@dgroups.org>
Subject: [hifa] CHWs (74) After Ebola: World Still
â€Grossly Underpreparedâ€™ For Outbreaks (2)

Dear Neil and HIFA colleagues,

I fully agree with the statement made that: Community engagement is key for successfully controlling outbreaks. Therefore for engagement of the community we should benefit from CHWs who is from the Community, serving them and are living with them.

I would like to share some observations that CHW could investigate the cause of a viral hepatitis and stop it by her initiatives. She found out that the viral hepatitis cases were coming from upper parts of the Khanishan village of West Azerbaijan Iran where the number 2 drinking water well was located. While lower part of the village where people were drinking water from number one well, were not infected. She with support and cooperation of the community leaders had stopped using water from the well number 2, of course with health education in the village public meetings and face to face contacts. After two weeks the number of viral hepatitis cases dropped and finally stopped.

In another observation Malaria which was eliminated in Northern parts of Iran, suddenly erupted after war between Iran and Iraq. The situation was very dangerous because in humid area of northern part of Iran the population of mosquitoes was very high and also the area is the most populated part of Iran. As far as the species of the Malaria in the northern parts of Iran was only Vivax. CHWs could stop the epidemic, with early detection and treatment of the cases with spraying by the ministry of health.

I should conclude that the best mean to engage community for successfully controlling epidemics is to rely on CHWs who is selected by the community and live there with support of all levels of the health system.

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