HIFA Thematic Discussion on Community Health Workers
16 January - 24 February
Narrative Summary

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

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Key messages

1. The greatest concern identified was the need for respect and recognition from community leaders and health professionals.
2. Other major concerns were lack of training and supervision; access to healthcare information; remuneration; equipment, medicines, and need for mobile phones/computers.
3. CHWs are asked to carry out a wide range and ever increasing number of tasks, but often without the appropriate facilities to enable this.
4. Career progression among female CHWs may be limited by gender and transport issues.

'CHWs feel unrecognised and undervalued by official health care providers which not only reduces morale but also creates a disjoint between perceived influence by community, and their actual influence, reducing their respect from the community. Furthermore, this lack of respect is reflected in their lack of training and supervision, and results in a paucity of avenues for them to voice their needs and concerns. '

Introduction

Community Health Workers (CHWs) are widely recognised as critical to meeting the health needs of people in low- and middle-income countries. To gain an understanding of the perceived needs of the CHW workforce and how it can be reinforced Healthcare Information For All (HIFA) held a major thematic discussion on CHWs between 16 January and 24 February 2017. The discussion was held on the main HIFA discussion forum (with parallel discussions on CHIFA (child health), HIFA-Portuguese, HIFA-French, HIFA-Zambia) and focused around 6 key questions.

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

2. How are these needs being addressed? Where are the gaps?
3. Are there enough and appropriate avenues for the voices of CHWs to be heard (by the relevant stakeholders / authorities)?
4. What are the mental health and psychosocial needs of CHWs? How can these needs be better addressed?
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?
6. How can we meet the information and learning needs of CHWs working in challenging conditions?

The discussion was intended to build on the learning from the Health Systems Research Symposium in Vancouver (November 2016) and current initiatives including the new WHO guideline on CHWs (in development). It led in to the Symposium on Community Health workers and their contribution towards the Sustainable Development Goals, 21-23 February 2017, Kampala, Uganda.

Study area and population

Everyone with an interest in the work of CHWs and the promotion of health in low- and middle-income countries was invited to contribute, acknowledging that HIFA members have unique experience and knowledge which they could use to bring clarity to these challenging questions

Sampling

Self-selecting sample which has knowledge of and access to the HIFA forum(s).

Data collection

Contributions were collected in 3 languages (English, French, Portuguese) from 61 HIFA members in 21 countries (Brazil, Burundi, Cameroon, Canada, Ethiopia, Ghana, Guinea-Bissau, India, Iran, Japan, Kenya, Netherlands, New Zealand, Nigeria, Pakistan, Rwanda, Switzerland, Tanzania, Uganda, UK, USA).

In addition, there were several anonymous contributions via WhatsApp groups in the local language from CHWs in Uganda, and ASHAs, Anganwadi workers and CHWs in India. These groups were set up independently by 3 HIFA members for the purpose of giving a voice to CHWs and connecting CHW networks with the wider global HIFA community.

Results

Week 1. Needs and Priorities

Number of respondents: 23
Countries included: UK, Nigeria, USA, Uganda, Cameroon, Pakistan, India, Kenya, Iran, Ethiopia.

Theme identified	Number of comments
Need for respect/recognition	13
Better liaison with Health services	4
Need for supervision/training	7
Provision of supplies	9
Remuneration	4
Logistics	3

Five notable areas were identified by this question. The need for recognition/respect, the need for better liaison with health services, the need for supervision and training, the provision of supplies and remuneration and logistics. The greatest concern identified was the need for respect and recognition, both from community leaders, and at varying levels of the health care 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 - India)

This issue appeared to underpin all the others raised. Increased respect would not only improve their ability to deliver health messages within a community but also facilitate the smooth handover of care of patients to appropriate professionals when necessary. Alongside the desire for respect the requirement for on-going training and supervision featured highly, implying that CHWs take pride in their work and wish to undertake their duties to a high standard.

“We must be given regular training.” (CHW- India)

Surprisingly the desire for recognition was far greater than that for remuneration, suggesting that CHWs are not primarily driven by financial motives. However, concerns were raised that CHWs are paying out of their own pocket for logistical resources such as photocopying, travel and mobile phones.

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

Respondents also identified a lack of resources or facilities require to complete their work. These range from computers or appropriate record books, and mobile phones, to more practical requirements such as umbrellas and gum boots.

Week 2. How are these needs being addressed and where are the gaps?

Number of respondents: 19
Countries included: UK, Burundi, Nigeria, Uganda, Kenya, USA, Japan, Pakistan, India, Canada, Netherlands, Iran, Ethiopia

Theme identified	Number of comments
Need for respect/recognition	4
Accountability	3
Occupation Health and Safety	6
Need for supervision/training	5
Transportation	6
Remuneration	12
Equipment	5
Supplies	5
Gender/cultural norms	4

While several themes raised in response to the previous question remerged in this discussion, principally surrounding respect, supervision and remuneration, several logistical considerations also arose. Facilities, equipment and supplies were raised as practical gaps, both in terms of macro equipment such as machinery, and sanitation, and in terms of supplies which enable to CHWs to carry out their work, such as drug kits. Such gaps included the provision of computers to perform record keeping, or mobile phones, which creates additional time pressure for CHWs. A need was also identified for personal protective equipment for CHWs, and occupational health care to protect them against communicable diseases.

“Co-ordinate supplies of ORS and other essentials with the programs so that we do not run short" (Asha, WhatsApp India)

The lack of supplies was at times felt to correlate with unclear acceptance of lines of responsibility. For example:

"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 centres 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." Agoustou Gomis, Burundi (translated from French)

However, the theme of responsibility was also raised in terms of communities' embracing their own health management.

Cultural considerations around gender and transportation presented specific challenges. In some areas women could not take advantage of transport means such as bicycles, or motorbike, either due to issues of modesty/gender expectations, or because they are not able to travel independently. This impacts both on their ability to progress from volunteers to more senior workers and supervisors, and their availability to work in certain geographical areas.

Week 3. Do CHWs have adequate opportunities to be heard?

Number of respondents: 15
Countries included: USA, UK, Uganda, Nigeria, Switzerland, Pakistan, India, Iran

Theme identified	Number of comments
Need for respect/recognition	9
Information access	10
Role of CHW – trust	6
Need for supervision/training	15
Definition of CHW	7
Being heard	2
Resources	10
Remuneration	2
Logistics	3
Performance	1

Discussion during week 3 covered a wide range of topics, with very little reference to the specific question. However, input from CHWs on this subject continued to focus around previously identified themes such as supervision, training, recognition, and resources. Feelings expressed regarding their lack of position "they do not have to listen to us" suggest that they do not feel adequately heard by staff in more professional or senior parts of their health systems and that their status in health services is undefined.

These sentiments tied in with other concerns expressed around the definition of a CHW, their role and remit, and the training they are given which may vary between a few days and a few months. It was acknowledged that CHWs provide culturally acceptable health care at ground level and are central to building trust with communities.

Theme identified	Number of comments
Need for respect/recognition	13
Need for supervision/training	3
Provision of supplies	2
Remuneration	7
Insecurity	1
Meetings	2
Neighbourhood spaces	2

"…they have an in-depth understanding of the community, culture and language…) Ambimbola Olaniran (UK)

However, discussions were unclear as to what determines a worker to be "skilled" or "unskilled", and highlighted that engagement with "unskilled" volunteers who learn through seeing and doing, can present other ethical issues.

"It cannot ever be right to permanently substitute properly learned knowledge, skills and competence with non-structured, haphazard and 'unregulated' seeing and doing." Joseph Ana (Nigeria)

Week 4. What are the mental and psychosocial needs of CHWs?

Number of respondents: 11
Countries included: Uganda, Nigeria, Rwanda, India, USA, Canada, UK

Whilst not focussing directly on the question posited, the ongoing discussions, both from CHWs themselves, and other contributors, continued to identify the repeated themes of respect, remuneration and training. The continued issue of respect and trust by the community, mirrored by the desire for recognition and approval by formal sectors of local health systems suggests that achieving this is an important factor in maintaining morale and supporting the mental wellbeing of CHWs.

Acknowledgement and involvement in the planning of local health activities was one avenue identified to support this.

"We want health centres to invite us for their planning meetings as some of the issues discussed during these meeting are of our concerns such as community outreaches." (VHT, Uganda)

Appropriate training and supervision of the CHW workforce was not only acknowledged to be the way forward in terms of enhancing the productivity of what is recognised as an essential, yet undervalued workforce, but also a means to reduce stress amongst CHWs. Equally remuneration would relieve pressure from their families, especially as despite being poor themselves they are paying out of their own pockets for resources such as transport.

"We are only volunteers, we should not use our own money for transport, instead we should be given some transport allowances to help us pick up drugs from health centres. If not, then health centres should deliver these drugs to us in our villages." (VHT, Uganda)

heme identified	Number of comments
Need for respect/recognition	8
Heavy workload	4
Need for supervision/training	5
Remuneration	12
Volunteerism and motivation	8
Corruption	4

A theme not previously identified was a desire by the CHWs to be supported to come together as a recognised group. This would not only provide opportunities or learning but also social support.

"We need to engage in sports activities and will be very grateful if they are organised for us. These activities will bring us closer as VHTs." (VHT, Uganda)

Week 5. Are we expecting too much of CHWs? Is there risk of burnout? How can their workloads be better rationalised?

Number of respondents: 21
Countries included: Nigeria, Uganda, Ghana, Brazil, Guinea Bissau, Rwanda, USA, Nigeria, Pakistan, India, USA, UK, Tanzania, New Zealand

Discussion in week 5 focussed heavily around remuneration, volunteerism and corruption. As has been raised in other weeks CHWs are frequently bearing associated costs such as transport and mobile phones, and are not being

compensated for these. Additionally, many would like to receive some form of fixed payment for their services as currently promised incentives are not delivered.

Several Ashas from India identified the importance of having a defined post and associated payment, which seemed to equate with the recurring theme of recognition and respect.

“If we have some official position then we will be better respected by the full-time staff.” Asha (India)

However, these desires raised concerns throughout the discussion that payment for services would impact of the motivation of CHWs to serve their communities and would reduce the sense of ownership that communities should have over CHW services.

“Some countries seem to be experiencing tension between formalising (and paying) the cadre of CHWs, and yet wanting communities to also support CHWs and to feel that CHWs are working for THEM.” Laura Hoemeke (USA)

The discussion regarding financing extended beyond fixed salaries to remuneration of costs incurred whilst carrying out their tasks. Opinions on this matter were strongly expressed, with some suggesting that CHWs should not be paying out of their own funds:

“All HWs should be paid refunds for their ‘out-of-pockets’ including transportation, snacks, air time etc.” Joseph Ana (Nigeria)

Whilst others felt that the meaning of volunteerism is contrary to the idea of reimbursement and would be counterproductive.

“Once volunteers start receiving stipends of any sort, it will water down the objective and, more importantly, (be) abused.”

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

Number of respondents : 24
Countries included: Uganda, India, UK, USA, Switzerland, Ethiopia

Theme identified	Number of comments
Regular supervision/training	12
Local Language	3
Literacy level	1
Electronic Media (eg. TV)	3
Manual training methods	3
Apps	3
Mobile Phones	7
Non-cash incentives	2
Technology	5
Demonstrations	1
Visits to and from other CHWs	1

The clearly resounding theme in this week's discussion was the desire for CHWs to have regular and on-going training and supervision to support their delivery of care based on accurate information. These supervision and training sessions could be supported using electronic media and other technology such as Apps. However this requires that CHWs be provided with mobile phones and/or computers.

"Technology, of course, is a great facilitator. Mobile phones appear to be fast becoming the best tool to help meet the diverse learning needs. In many of our community settings work can be very challenging and trainers also are few in number in such areas. Countries should invest in improved net connectivity." Sunanda Reddy, India.

Surprisingly little mention was made of the need for resources to be in the local language. This is perhaps because technology based learning aids may often have translation abilities, or language selection. However it was raised that traditional learning resources need to be in local languages, and relevant to literacy skills.

"We should be provided with reading booklets written in our local languages. These booklets should be small in size as big ones are hard to read." CHW, Uganda.

"IEC materials are also very helpful as they are easy to understand even when one does not know how to write." Carol Namata, Uganda on behalf of CHWs .

Conclusion

Three recurring themes were clearly expressed throughout the discussion indicating decidedly unmet needs on the part of the CHW workforce. These were:

1. The desire for respect.
2. Training and supervision
3. Facilities
4. Remuneration

CHWs feel unrecognised and undervalued by official health care providers which not only reduces morale but also creates a disjoint between perceived influence by community, and their actual influence, reducing their respect from the community. Furthermore, this lack of respect is reflected in their lack of training and supervision, and results in a paucity of avenues for them to voice their needs and concerns. Although resources may be stretched reducing the ease of providing face-to-face training and supervision, the technology is available to facilitate this using video chats such as Skype, simple text messaging and training Apps.

CHWs are asked to carry out a wide range and ever increasing number of tasks, but often without the appropriate facilities to enable this. Given the acknowledged influence CHWs have in meeting the health needs of communities it is critical that the workforce is reinforced and supported to deliver this service. Provision of basic facilities and supplies is essential in achieving this. If CHWs are not appropriately supported and equipped there is a high risk of burnout. Many perform their roles on a voluntary basis but would prefer to receive remuneration for their efforts. At the very least volunteers do not believe they should be covering costs out of their own pocket. This not only affects motivation, but given many come from poor communities, also creates tensions with their families as they are ill able to accommodate this financial pressure. While MHPSS was inadequately addressed in responses clearly motivation and morale was closely linked to the above stated themes. If the continued and growing role that CHWs have in delivering community based health care is to continue the workforce needs greater support to rise to the challenge of meeting the SDGs.

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Abhi Goyal, USA 2 messages	Jenny Ure, UK	Mickey Rostoker, Canada
Abimbola Olaniran, UK 2	Jenny Yamamoto, Japan	Miriam Taegtmeyer, UK
Agoustou Gomis, Burundi	Jette Fausholt, Uganda	Mohammad Ali Barzegar, Iran 5
Alex Little, UK	Jill M. Peterson, USA 2	Muhereza Chrisestome, Uganda
Alhassan Aliyu Gamagira, Nigeria 3	John Miescher, Switzerland	Neil PW (moderator) 32
Baba Aye, France	Joseph Ana, Nigeria 7	Netradipa Pradip Patil, India 2
Bolaji Akerele, Nigeria	Judith Tchuenkam Sandrine Nem, Cameroon	Nicholas Cunningham, USA
Carol Namata, Uganda 7	Kausar Skhan, Pakistan 11	Obi Egbuniwe, USA 3
Chandrakant R Revankar, USA	Kavita Bhatia, India 15	Ochiawunma Ibe, USA
Charles Eziuzor, Nigeria	Kenneth Maes, USA/Ethiopia	Polly Walker, UK
Charles Ssemugabo, Uganda	Khalid Iqbal, Pakistan	Ram Shrestha, USA
David Musoke, Uganda 7	Laura Hoemeke, USA	Remi Akinmade, Nigeria
Dennis Odwe, Uganda	Linda Gibson, UK	Romiya Barry, USA 3
Don Sutherland, Canada 1	Lucie Byrne-Davis, UK	Rosalind Steege, Ethiopia 3
Donna Bjerregaard, USA 2	Maisam Najafizada, Canada 2	Ruth Martis, New Zealand 2
Eben Afari-Kumah, Ghana	Malcolm Brewster, UK	Sally Theobald, UK
Elizabeth W Ridgway, USA	Marg Docking, USA	Samuel Senfuka, Uganda
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G Karanja, Kenya	Martin Carroll 2	Sharuna Verghis, Malaysia
Hannah Faal, Nigeria	Maryse Kok, Netherlands	Sunanda Kolli Reddy, India 5
Jean Bosco Gasherebuka, Rwanda 2	Massimo Serventi, Tanzania	
Jean Sack, USA	Meghan Brucekumar, Kenya	