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Health Systems Action Network

Highlights…

Virtual "Ask the Expert" Session on the Role of Community Health Workers (CHWs)

Expanding Access to Essential Health Services in Developing Countries

From July 16 to August 3, 2007, HSAN hosted its first virtual "Ask the Expert" session. The session was led by Dr. Frank Nyonator from Ghana, and Dr. Mushtaque Chowdhury from Bangladesh.

The chosen topic was the role of community health workers (CHWs) in expanding access to essential health services in developing countries. Questions and comments, along with responses, were posted to HSAN's public website. The goal of the session was to share experiences of what has worked well, where, and what factors have contributed to success.

Key issues discussed during the session included:

- ◊ The importance of CHWs in many different communities worldwide
- ◊ Whether to train additional CHWs vs. training existing health workers
- ◊ The (often not supportive) attitude of doctors and other health personnel towards CHWs
- ◊ Health system elements required to support CHWs/ linkage of CHWs with the health system
- ◊ Incentive/motivation/resources for CHWs
- ◊ CHW community participation
- ◊ Monitoring of CHWs
- ◊ Sustainability
- ◊ Evidence of training effectiveness
- ◊ Standardization of training
- ◊ The role of CHWs in data collection and reporting
- ◊ CHWs and safe delivery

MCH Program,
Batticaloa, Sri Lanka

HSAN is a global network of committed professionals for strengthening health systems through effective involvement of diverse stakeholders and better management of resources that is guided by evidence. HSAN's vision is to become a leading global network facilitating the development of equitable, accountable and sustainable health systems for improved health outcomes.

Highlights from the Ask the Expert Session: Sample Q&A

Q&A #1 (question from Pakistan)

Over the past 20 years working in Pakistan and East Africa, I have learned that CHW programs fail if they are not consistently backed by the formal health system. However, the major difficulty of formally trained health providers (particularly doctors) not accepting CHWs continues to be a challenge. I am aware of numerous examples where a CHW brought in a sick child who had been provided simple treatment by the CHW, and the CHW was insulted by doctors for not doing a good job. As a result, the CHWs were offended and stopped referring patients to that health facility. Have you also faced similar problem and how have you been able to resolve this dilemma?

MCH Program, Batticaloa, Sri Lanka

Mushtaque Chowdhury (MC) response: A great question. This problem is raised quite often and we do face this from time to time. This is particularly true when the services provided by doctors (or para-professionals) are less than the demand. In a recent program, we are trying to address the issue of maternal newborn and child health through an intensive community-based intervention. For reducing mortality (of mother and newborn) some cases require specialized facilities such as emergency obstetric care (EmOC). We are trying to link the community-based activities (with CHWs as the nucleus) with facilities where available. There are instances where the cases referred by CHWs are given less importance. To address this, we are trying to motivate the EmOC staff to be more sympathetic to the referred cases. Also, as a pilot, we are posting one of our colleagues at these facilities to liaise and do the motivation work. We are mindful of the risk attached that the facility staff may treat the patients referred by us more carefully than others just because of our presence there. For the success of a CHW program such as above, the support and sympathy of doctors is very important. In this the role of NGO is very important. They must prepare their doctors to work with CHWs as members of the system. There are instances, where the doctors tend to use CHWs as 'bureaucratic servants' to deliver government services. In such a situation the CHW program is destined to fail.

Frank Nyonator (FN) response: Indeed, these experiences abound, especially in our settings where traditional community health workers are not seen as professionals and not part of the health systems. Hence the non-acceptance of their contributions to service provision by the professional cadres. Clearly, these are some of the difficulties that shape the decisions of most countries, like Ghana, to deploy mid-level cadres of the health system to stay in communities as community health officers. However, there has been a massive drive in Ghana to create awareness that the community level is an integral part of the health system and that the types of cadres that work there are especially important. It is hoped that this will be able to influence the attitudes of the various levels of health workers to each other.

Q&A #2 (question from Ethiopia)

How could community health workers be better linked to the conventional health system?

MC response: Ideally the CHWs should be the lowest level link for the health system. They should be the link with the community for which the system works. The health system needs to understand the contributions and acknowledge the role of CHWs in making the health system work effectively. The CHWs should also be seen (and ensured) as the monitor of health system activities on behalf of the community ('the community voice'). On the other hand, the health system should also ensure the training of CHWs, both basic and continuing, and provide supportive supervision for their work.

FN response: In the experience of Ghana, the Community based Health Planning and Services (CHPS) initiative ensures that the CHWs are part of the formal health system (designated as community health officers) and are paid by the formal system. In other experiences, the CHW's are outside the formal system and had issues about supervision and sustainability.

Q&A #3 (from the United States)

I'm concerned that CHWs are being overburdened with excessive donor reporting requirements, taking away from their principal role of serving the health care needs of their communities. What improvements or innovations to health services delivery could be made to reduce the amount of time required for information and data gathering and reporting so that health workers can better serve the public health care needs?

FN response: You are right, but the community health workers are not only being overburdened by the donors, but also by the local health authorities. Where they have been rolled out, CHWs are being increasingly seen as polyvalent workers and being assigned additional tasks with their various reporting systems. They are becoming the proverbial 'beast of burden' to deliver all health interventions and report on them. We are seeing, increasingly, burnt out community health workers and plans are being made to resolve this. A key strategy within Ghana's CHPS initiative is to pair CHWs with community health officers and assign specific tasks. Another strategy is to introduce Personal Digital Assistants for data collection at the community level thereby reducing the time spent on manual reporting of data collected. The CHPS is in the process of piloting these in a few communities and should be able to share the results very soon.

Courtesy: The CHPS M&E Secretariat, PPMED. Ghana Health Service

Q&A #4 (from Sri Lanka)

At the moment we are training Community Health Volunteers (CHVs) from camps of Internally Displaced Peoples (IDPs) to support the IDPs in getting proper health care from existing health facilities and to create awareness with basic health messages. But because of staff shortages and the short project duration, it has become difficult to monitor the activities of CHVs. Please share your experience with the following:

- *How to develop effective monitoring systems with few project staff in a short time period?*
- *Strategies for better sustainability of the CHVs training program?*

[Simplified] response from Tarry Asoka (HSAN member): An effective support system for CHVs involves more than just monitoring and supervision. It involves follow-up support and encouragement that requires plenty of understanding and patience. It should also be regarded as a two-way feedback mechanism. An ideal support system for CHVs should be made up of 4 different sources: 1. The health worker's community - especially where an effective Community Health Committee is functional, 2. Other health workers in nearby communities, especially those who have been working longer and have more experience, 3. Instructors or Advisers from the Health program itself and 4. Hospitals, Clinics and Agencies to which special problems can be referred to. Although instructors or adviser from the training program may appear to be the best persons to provide health workers with follow-up support, the particular situation at hand should be evaluated to see which of the sources outlined above would best meet the requirements. In most instances multiple sources may be used to reinforce this supportive framework. ■

HSAN Events:

Voices from the Field Stress Strong Health Systems to Achieve Results

On May 29, 2007, HSAN held a satellite meeting at the 34th Annual International Conference on Global Health in Washington, DC that focused on health systems strengthening needs from the perspective of developing country practitioners.

HSAN panelists were: Frank Nyonator (Africa Region), Irene Agurto (Latin America and Caribbean Region), Mushtaque R. Chowdhury (South East Asia Region) and George Khechinashvili (Eastern Europe and Central Asia Region). The moderator was Laurie Garrett, Senior Fellow for Global Health at the Council on Foreign Relations. The session was attended by over 200 people.

Using stories and examples, the panelists stressed the need for global health initiatives to consider local realities, priorities and epidemiology. Examples included a governmental donor coordination office in Ghana, and Ethiopia, Botswana and Mozambique; more attention to the non-communicable diseases epidemic in Eastern Europe and Central Asia, supporting the workforce development in Guyana, and the integration of the MoH and family planning program in Bangladesh as an attempt to overcome the limitations of a single vertical program. The panellists also described specific examples of successful or less successful attempts in their countries to reach the poor. ■

Panelists (from left to right) George Khechinashvili, Irene Agurto, Frank Nyonator and Mushtaque Chowdhury. Panel moderator Laurie Garrett (center).

Upcoming HSAN Events

HSAN 's next virtual "Ask the Expert" session is expected to take place in mid to late September, run 2-3 weeks and focus country-specific successful and unsuccessful experiences with making affordable and effective interventions widely available. Two of HSAN's founding members, Grace Murindwa, a Senior Health Planner and Management Specialist from the MoH in Uganda and Edwin Bolastig, a UN Volunteer Health Policy, Planning and Financing Specialist, currently attached to the Ministry of Health of the Republic of Trinidad and Tobago will lead this discussion. To learn more about this or other events, please visit the HSAN website.

HSAN's quarterly e-newsletter provides regular overviews of current issues in health systems strengthening, and updates on ongoing and upcoming HSAN activities. To learn more about HSAN, become a member and/or join the mailing list , please go to **www.hsanet.org.**

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