CHW experience during the COVID-19 response: understanding their roles, challenges and adaptive strategies

Solomon Salve, Kate Gooding, Joanna Raven

Background and rationale

- Increased recognition of CHW roles in pandemic response, including for COVID-19
- Significant learning on CHW experience during COVID-19 in OPM reports over 2020-21 – range of research, evaluations and analysis, each focused on one country

➔Synthesis of findings to provide cross-country comparison, bring out bigger picture and broader learning, and enable wider dissemination

Synthesis research questions:

- What roles have CHW played in the COVID-19 response?
- What support was provided to CHW, and how effective was this support?
- What challenges did CHW experience?
- What adaptations enabled continued service delivery?

Methods

Synthesises evidence from research and analysis conducted or supported by OPM over 2020-21:

- Six countries: India, Bangladesh, Pakistan, Sierra Leone, Kenya and Ethiopia
- 25 reports from18 studies - some studies produced multiple reports through a series of assessments over time
- Methods varied, but primarily qualitative - included interviews, focus groups and document reviews

- Initial rapid reading to map range of information available
- Thematic framework developed – drawing on research questions, literature, early reading
- Framework applied to code information in reports
- Material under each theme exported for further analysis
- Draft findings shared with key OPM contacts that conducted original research - to check interpretation and clarify information

Material

- Reports from Maintains - an FCDO-funded research programme on shock-responsive services (eg CHW roles in the COVID-19 response, supplies and training for CHW)
  - **Bangladesh, Kenya, Sierra Leone** - Rapid COVID-19 response country study
  - **Pakistan** - Response & Preparedness for Essential Health and Nutrition Services During Disasters In Pakistan
  - **Sierra Leone**: The effectiveness of the Sierra Leone health sector response to health shocks: Evidence from the COVID-19 perception survey; Beyond the state: The role of traditional leaders in COVID-19

- **India –** Covid-19 research projects (Role of Indian Frontline Workers; Experiences of Elected Women Representatives; Experiences of Community Women; PHC Preparedness and Impact on Services)

- **Bangladesh** - Essential health services during COVID-19, including CHW services (eg impact on routine services, challenges, adaptations/coping strategies)

- **Ethiopia** – situation analysis on nutrition services, largely delivered by CHW (including effects of COVID-19 on service delivery)

Community Health Workers

Country	CHW Cadre
Bangladesh	Community Healthcare Provider
	Family Welfare Assistant
	Family Welfare Visitor
	Health Assistant
	Shasthya Sebikas
India	Auxiliary Nurse Midwife
	Accredited Social Health Activist
	Anganwadi Worker
	ASHA facilitators
Kenya	Community Health Extension Worker
	Community Health Volunteer
Pakistan	Lady Health Worker
Sierra Leone	Community Health Worker
Ethiopia	Health Extension Worker

Community health workers (CHWs) are:

- health workers who are the first point of contact at community level,
- based in communities or at peripheral health posts, and
- who have some but fewer than two to three years of training

There's huge diversity in this group, eg in employment status & training

Findings

CHW roles in the COVID-19 response

- Identification and surveillance *(such as house screening, screening of people with COVID-19 symptoms, contact tracing, or reporting potential infections to district health teams)*
- Community education and awareness on COVID-19
- Counselling migrants / track migrant movements
- Enforcement of household lockdown for the identified COVID-19 cases and/or returnee migrants
- Follow-up of patients with COVID-19
- COVID-19 vaccination *(raising awareness / delivery of vaccine)*
- Other *(provide rations)*

Support provided to enable CHW work during COVID-19

- Support from the formal health system
  - Training
  - PPE
  - Financial support
  - Managerial support for CHWs during COVID-19

- Support from families, peers, and the community

Support from the formal health system

Training

Topics covered
- Contact tracing and case management, safe provision of routine services, etc.

Several countries conducted some training online or via mobile phones
- e.g. Kenya, Ethiopia, India

Some gaps
- India: gaps in smartphone access, not all CHWs trained, no follow up, some without information on COVID-19 etc.

Personal protective equipment (PPE)

Insufficient PPE for CHWs across countries - quantity and quality, issues of distribution
- Bangladesh: only 3 PPE sets over first year, India: shortages of masks and sanitiser
- India & Kenya: PPE prioritised for staff working on COVID-19, limited for routine services
- India: gendered health service hierarchies: PPE allocated to (male) doctors/managers

Variation between CHWs and cadres
- India: ANMs received more PPE than ASHA, more personal finances to purchase own PPE

Inadequate PPE left CHWs anxious and vulnerable to infection

CHWs voiced a sense of disempowerment and neglect, and described themselves as "small people" (or lowest in the rung) for PPE distribution

Support from the formal health system *cont.*

Financial Support

In some countries, financial incentive schemes were introduced

- eg Bangladesh, India, Pakistan - several incentives/life insurance announced

Gaps in implementation of COVID-19 financial incentives

- India: incentives varied between CHW cadres, often delayed, CHW unaware of entitlements
- Ethiopia: CHWs used own money to share COVID-19 information by phone, without compensation

Managerial Support

Support when targets were not achieved due to COVID-19

- India: support in reporting low caseload, and timely submission of reports

COVID-19 further reduced the quality of already inadequate supervision

- India: supervision less frequent, often over phone, focused on disseminating instructions and discussing tasks related to COVID-19 rather than addressing CHW concerns

Support from families, peers and community

Families

Families as a source of support for some CHW

- India: some CHWs relied on their husbands and relatives to provide transport to facilities and communities

Peers

Covering additional hours and discussing tasks

- Bangladesh: some CHWs worked additional hours to cover for CHWs who could not reach the clinic during lockdown
- India: regular discussion among CHWs and with other stakeholders on COVID-19-related work, eg management of returnee migrants, food distribution

Lack of support

- India - lack of peer collaboration/support also reported, for COVID-19 or routine work

Community

Support from community members/stakeholders

- India: support from volunteers, self help groups etc with COVID-19 work, eg provide information, quarantine, surveillance and awareness raising, manufacturing face masks
- India: Elected Women's Representatives conducted service delivery activities when CHWs were on strike due to lack of incentives, or unable to travel due to lockdown measures

Challenges experienced by CHWs in providing services during COVID-19

- **Health system factors**
  - Staff time and availability and workload
  - Medical supplies

- **Restrictions related to COVID-19 public health measures**
  - National guidelines and regulations on gathering and physical distancing
  - Wider movement restrictions and impacts of travel

- **Community access, demand and beliefs**

Challenges #1: Health system factors

Staff time and availability and workload

COVID-19 added to CHWs' existing workload - long hours, notable gender variations, created stress

- Ethiopia: new COVID-19 tasks meant CHWs deprioritised routine nutrition services
- Bangladesh: some staff could not work due to COVID-19 isolation/vulnerability – so other CHWs worked overtime and at weekends to cover caseload
- India: difficulty in balancing COVID-19 work and routine activities

Medical supplies

Disruption to medical supply chains led to shortages, often exacerbating existing difficulties

- Ethiopia: disrupted supply of iron/folic acid/vitamin A for CHW nutrition services
- Bangladesh: lockdown hindered transport of medical supplies needed by CHWs
- India: lockdown disrupted supply of the rations distributed by CHWs

Challenges #2: restrictions related to COVID-19 public health measures

National guidelines and regulations on gathering and physical distancing

Some CHW services suspended

- Bangladesh: household visits to distribute contraceptives paused
- India: outreach days for ANC and immunization paused

Restriction on gatherings - some community-based activities could not take place or were more difficult

- Ethiopia: CHW-led nutrition screening involves community gathering so became harder

Wider movement restrictions and impacts of travel

CHW ability to access their place of work and communities

- Bangladesh: daily commute to the community clinic difficult; at times had to walk far to collect COVID-19 samples from patients
- India: transport shortages made it hard to collect and distribute home rations
- Ethiopia: community visits became difficult

Transport unavailable/increased costs

- Bangladesh, India and Sierra Leone: halted transport
- India, Bangladesh: reallocation of ambulances to the COVID-19 response

Challenges #3: Community access, demand and beliefs

Travel restrictions	**Affected the demand side of health services** • India: lack of transport hindered women's ability to access ANC services
Community fears of infection or quarantine	**Reluctance to attend/allow CHW services** • Ethiopia: fear of infection reduced community visits to facilities • Bangladesh and India: some community members did not allow CHWs to enter their homes due to concern about infection
Community concerns about stigma	**Affected community trust in CHW and CHW's ability to perform their tasks** • India: CHWs expected to identify people with COVID-19, but community members reluctant to report symptoms due to fear of stigma or quarantine
Community concerns about infection	**Stigmatization of CHWs** • Bangladesh: CHWs refused access to public transport when wearing PPE • India: suspicion that CHW working as informers to facilities or the police

What adaptations enabled CHW work?

- Telemedicine
- Provision of medical supplies
- Service delivery locations
- Structure of service delivery
  - Use of COVID-19-related activities to provide other services
- Additional ways to maintain services and support communities.

Adaptations to enable service delivery

Telemedicine (phone calls)

- Bangladesh: counselling; follow up TB patients for compliance with DOTS via phone
- India and Pakistan: checking health of pregnant and postnatal women, screening for COVID-19 symptoms

Problems:

- Reduced quality of service provision; hindered interpersonal communication;
- Approaches could not reach all those in need

Provision of medical supplies in advance

- Bangladesh: provided clients with additional quantities of oral pills and male condoms before lockdown
- India and Bangladesh - TB patients provided with additional medicines

Adaptations to enable service delivery cont.

Service delivery locations

Immunisation sessions could not be held in people's homes

- Bangladesh: CHWs used schools, as they were closed, available, provided more space.

Facilities were closed or CHWs could not make household visits

- Bangladesh: supplied TB medications or contraceptives from their own homes
- Pakistan: provided maternity services for pregnant women from their own homes

Structure of service delivery

Using smaller groups to adjust to restrictions on large gatherings

- Ethiopia: some CHWs divided villages into smaller units

Using COVID-19 activities to provide routine services

- India: some CHWs advised to use COVID-19 survey household visits to provide ANC and other services

Additional adaptations

Personal commitment

CHWs working long hours

- India: busy with COVID-19 response activities during day time, worked at night to escort pregnant women to facilities for delivery
- Bangladesh: worked overtime

Used of own financial resources to overcome constraints

- India and Bangladesh - purchasing their own PPE
- India and Bangladesh - covering extra transport costs

Providing support to community members in need

Rising food prices/Income loss left household vulnerable to malnutrition

- Pakistan: CHW distributed rations on their own

Adaptations were also associated with a lack of choice and power, with many CHWs in India describing their situation during COVID-19 as involving 'majboori', or helplessness and lack of options

Conclusion

- **Multiple CHW contributions** to COVID-19 response
- CHW work and wellbeing affected by:
  - **health system factors**, eg supply chains, insufficient human resources
  - **wider government decisions**, eg public health measures, movement restrictions
  - **gendered hierarchies**, eg in PPE distribution, risks, domestic workloads
  - **community** relationships e.g. support, distrust, stigma
- Inadequate support and other challenges **affect CHWs' wellbeing -** stress and fear
- **Varied experience** between CHW cadres and individuals (more work needed on heterogeneity)
- CHW agency and commitment to maintain services – **resilience**, or **coping** in systems with inadequate support?

➔ **CHWs need adequate resources, managerial and financial support to support their contribution and protect their wellbeing**

Thank you

rebuildconsortium.com
@ReBUILDRPC

solomon.salve@gmail.com

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