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Exploring community health worker roles, support, and experiences in the context of the COVID-19 pandemic in Bangladesh

Frontline Health Project

Frontline Health
Harmonizing Metrics, Advancing Evidence, Accelerating Policy.

RESULTS BRIEF

JUNE 2021

EXPLORING COMMUNITY HEALTH WORKER ROLES, SUPPORT, AND EXPERIENCES IN THE CONTEXT OF THE COVID-19 PANDEMIC IN BANGLADESH

BACKGROUND

Community health workers (CHWs) are critical actors within community health systems, providing a range of reproductive, maternal, child, and primary health care information, counseling, and services. As community members, CHWs understand the local context and link their communities to care [1]. In pandemics like COVID-19, they continue to provide routine services in addition to undertaking increased responsibilities. While CHWs are innovative in their strategies to sustain their work, they operate under challenging circumstances including limited guidance and support and potential hostility from communities and/or facility-based providers.

Bangladesh's CHWs – specifically, government-employed cadres known locally as Family Welfare Assistants (FWAs) and Health Assistants (HAs) – continue to work during COVID-19. Typically, both FWAs and HAs provide a range of counseling and services on family planning and general health, respectively [3,4]. In addition to providing health information and counseling at the household level, FWAs and HAs work closely with primary health care centers at upazila and union levels.

COVID-19 was first detected in Bangladesh on 8 March 2020, and there were 772,187 confirmed cases and 11,878 confirmed deaths in the country as of 8 May 2021 [2]. At the onset of the pandemic, with technical guidance from the Ministry of Health and Family Welfare (MoHFW), the government initiated strategies to prevent the spread of COVID-19. These included district/area lock downs and periodic country-wide lock downs, enforcing mask-wearing and social distancing in public, promoting safe hygiene practices, enforcing isolation/quarantine for suspected/confirmed cases, facilitating institutional treatment, and facilitating community-based prevention practices by engaging CHWs to respond to COVID-19 in their communities [5].

The government initiated vaccine provision for all adults over 40 years of age in February 2021. While there is currently no engagement on vaccines at the community level, CHWs help create awareness.

This brief presents results from the Frontline Health project's study in Bangladesh which explores CHWs' perspectives on educating communities, providing care, and health reporting during the pandemic.

KEY FINDINGS

1. In Bangladesh, CHWs continue carrying out their routine work at slightly decreased levels during COVID-19 compared to the beginning of the pandemic.
2. CHWs are educating households and connecting clients to advanced care for COVID-19; however, they are receiving less supportive supervision during the pandemic.
3. CHWs face instrumental and health/safety challenges while working, including a lack of adequate masks, hand sanitizer/soap, and gloves; barriers to travel; and inconsistent or inadequate training on COVID-19 screening, reporting, and referring.
4. As key providers of health education in their communities, CHWs are in an optimal position to inform their clients about misconceptions surrounding the COVID-19 vaccine and encourage its uptake.

Data collection took place from November – December 2020 in four discricts in Bangladesh: Khulna, Rajshahi, Sylhet, and Cox's Bazar. The information presented in this brief is based on a quantitative survey with FWAs (n= 204) and HAs (n= 166) performing routine services during COVID-19. This study is part of a larger portfolio of work under the Frontline Health project which seeks to advance community health systems metrics, monitoring, and learning to improve the efficiency and performance of CHW programs.

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RESULTS

Quantitative survey results revealed that 81% of CHWs in our sample (n= 370) are female, 31% are between 30-40 years old and 35% are over 50 years old, and 75% received a higher secondary and above education.

Most CHWs reported that they had been working over 10 years (85%), with very few CHWs reporting less than five years' experience (5%).

Among CHWs that reported living in the community in which they work (n=254), the average travel time to the farthest household was 11-20 minutes, followed by 21-30 minutes.

TABLE 1. CHARACTERISTICS OF CHWS (N = 370)

Characteristic	FWA (%) [n=204]	HA (%) [n=166]	Total (%) [N=370]
Gender			
Female	100	57	81
Male	0	43	19
Age			
1<30 years	11	2	7
30 - 35 years	20	18	19
36 - 40 years	4	21	12
41 - 45 years	5	6	6
46 - 50 years	20	25	22
>50 years	40	28	35
Education level			
Secondary (Incomplete)	3	0	2
Secondary (Complete)	42	1	23
Higher secondary and above	55	99	75
Time working as a CHW			
< 5 years	9	1	5
5 - 10 years	13	4	10
> 10 years	78	95	85
Received incentives*			
Salary	100	100	100
Allowances (transport, lunch, airtime)	80	84	82
Non-financial (food, backpacks)	70	82	75
Location of CHW's work			
Urban informal settlements	12	2	7
Peri-urban	10	31	20
Rural	78	67	73
Time to reach farthest household among CHWs that live in community**			
10 minutes or less	27	7	20
11 - 20 minutes	41	41	41
21 - 30 minutes	23	34	27
>30 minutes	9	18	12
Main mode of travel since pandemic			
By foot	23	4	14
Bicycle	0	2	1
Motorbike	7	21	13
Bus	1	3	2
Taxi/ CNG taxi	31	40	35
Easy bike/ rickshaw/ boat	38	30	35

**Multiple responses, ** N=254*

CHWs continue to provide routine services in their communities at relatively high levels.

Our data indicate that the majority of CHWs were able to carry out their routine work during the pandemic, with some disruptions in routine activity at the beginning.

At the onset of the pandemic, almost 12% of CHWs (n= 44) reported that they were not able to carry out their routine work at all and 27% of CHWs reported that they were able to carry out their routine work "somewhat" (n= 101). Among these CHWs (n=145), 77% reported physical security concerns, followed by lack of transport (70%), communities' refusal due to fear of infection (69%), medical safety concerns (65%), and work shifting to COVID-19 (9%) as the reasons why they could not continue their work as usual (Figure 1).

Six months into the pandemic, nearly all CHWs were able to carry out their routine work (data not shown).

CHWs are providing services less frequently during the pandemic than they were prior.

The percentage of CHWs providing routine services decreased slightly during the pandemic, as some shifted their work completely towards COVID-19 or they were unable to carry out their work due to various pandemic-related challenges as shown in Figure 1. However, prior to the pandemic, CHWs were providing services at high frequencies close to 100%, and some of the decreases were only slight. For instance, the percentage of CHWs providing counseling and direct primary health care services decreased from 100% prior to the pandemic to 96% six months into the pandemic (Figure 2).

FIGURE 1. CHWS' REPORTED REASONS FOR NOT CARRYING OUT ROUTINE TASKS AT ONSET OF PANDEMIC (N = 145)

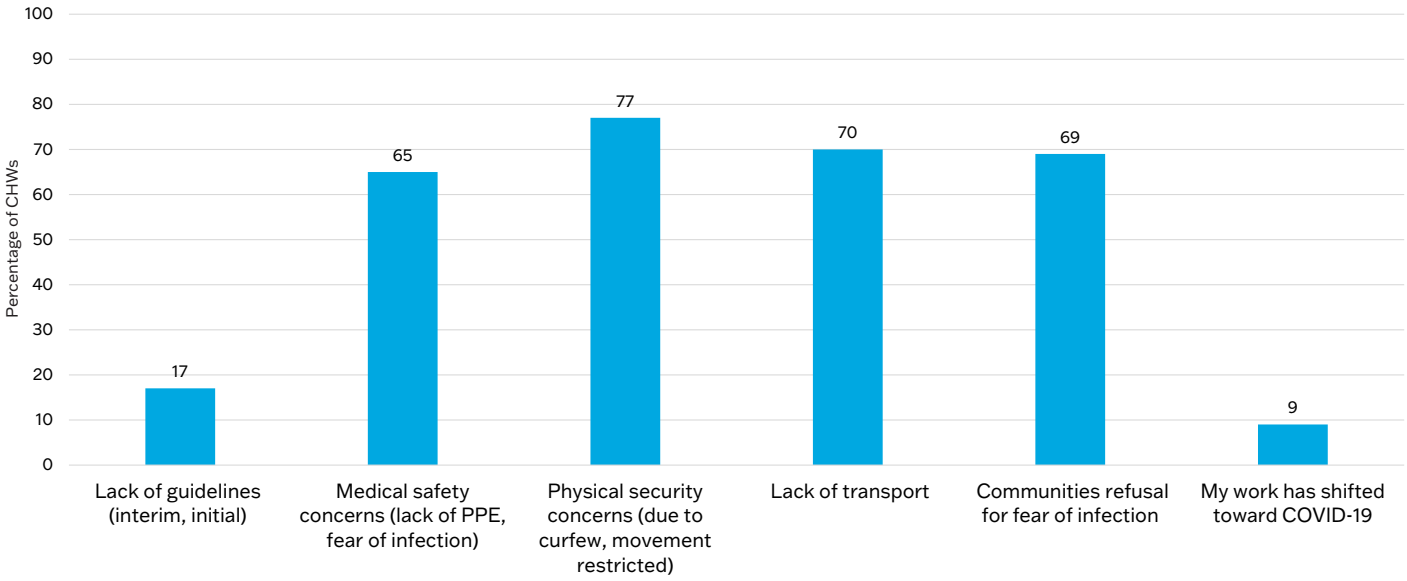
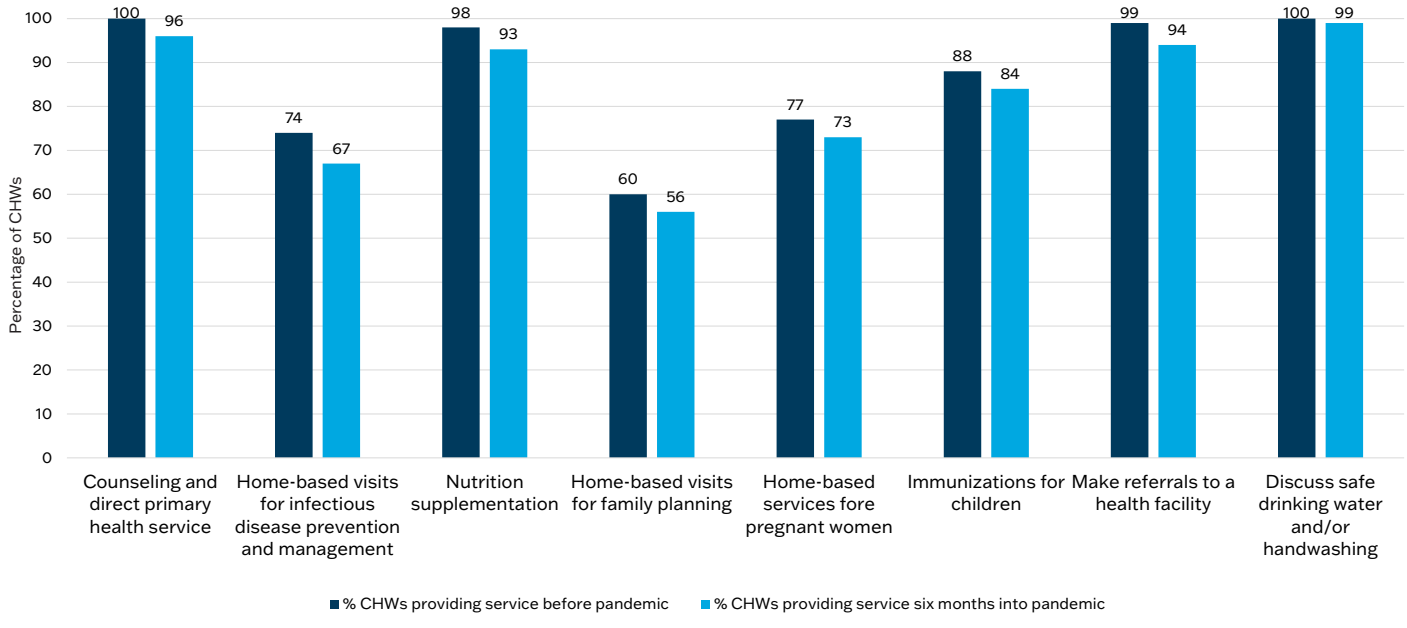


FIGURE 2. CHWS' RESPONSIBILITIES BEFORE AND DURING THE PANDEMIC (N= 370)



CHWs also reported slight decreases in home-based care for postnatal women and newborns, mental health counseling, documenting or referring for gender-based violence (GBV), and education on water, sanitation, and hygiene (WASH), among others (data not shown).

CHWs reported decreased in-person supportive supervision during the pandemic.

Our data show that most CHWs were supervised through ad-hoc in-person one-on-on meetings or regularly scheduled team meetings with their supervisors prior to the pandemic; however, during the pandemic, the number of CHWs reporting in-person methods of supervision decreased slightly. The percentage of CHWs reporting supervision through phone calls stayed the same during the pandemic (91%), while the number of CHWs reporting that they were supervised through digital communications (WhatsApp) increased from 18% to 33% (data not shown). Overall, CHWs are receiving less frequent direct supervision and support than they were prior to the pandemic, with the exception of digital communications.

CHWs reported engaging in various activities in their communities related to prevention, treatment, referring, and reporting COVID-19.

Eighty percent of CHWs in our sample (n=296) reported that they received any training or guidance on COVID-19-related services, with variable training on specific aspects related to contract tracing and continuing of community-based services (Table 2). Of the CHWs who reported receiving training, 64% reported those training messages were “very clear” (data not shown).

Ninety-nine percent of CHWs reported educating community members about COVID-19 prevention or treatment (Table 3). Almost all CHWs reported giving specific advice to their communities on prevention and treatment such as wearing masks, frequent hand washing/sanitizing, and social distancing, and the majority gave advice on what to do if exposed or symptomatic (Figure 3).

Almost 100% of CHWs reported educating their communities about how to take care of someone with COVID-19 in the home, 69% reported referring suspected COVID-19 cases for testing, and 61% indicated they report suspected or confirmed cases. Fewer reported contract tracing for community members who may have COVID-19 (35%) and reporting suspected cases for advanced care (33%) (Table 3).

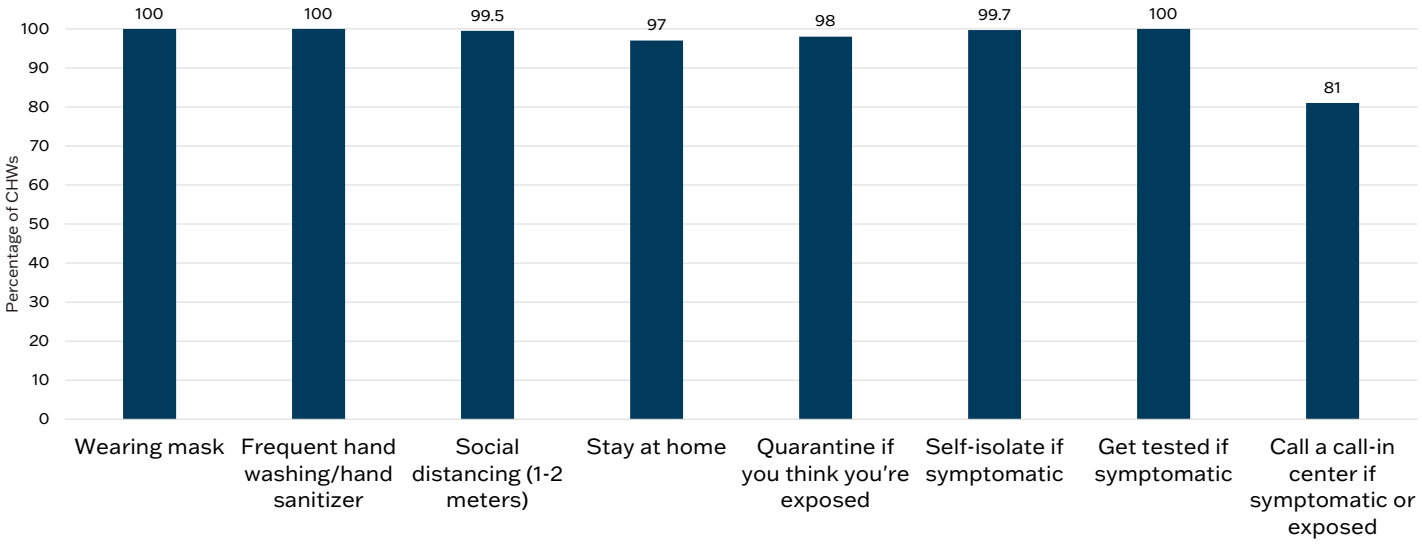
TABLE 2. CHW TRAINING/GUIDANCE ON COVID-19 (N= 296)

Percentage of CHWs reporting training or guidance on specific topic	%
General information about COVID-19	100
Preventive strategies (hand washing practices, social distance, self-quarantine, etc.)	100
Correct use of PPE (masks, gloves, apron, etc.)	98
Signs and symptoms of COVID-19	99
Contact tracing and community surveillance	57
Home based care of COVID-19 cases	85
Continuity of community-based services	73

TABLE 3. CHW COVID-19 ACTIVITIES (N= 370)

Percentage of CHWs engaged in COVID-19 activity	%
Educating community members about COVID-19 prevention or treatment	99
Educating communities/households about how to take care of someone with COVID-19 in the home	100
Referring suspected COVID-19 cases for testing	69
Reporting suspected or confirmed cases of COVID-19	61
Doing contract tracing for those who may have COVID-19 in the community you serve	35
Referring suspected COVID-19 cases for advanced care at facilities	34

FIGURE 3. PERCENTAGE OF CHWS GIVING SPECIFIC ADVICE ON PREVENTION AND TREATMENT (N= 367)



CHWs experienced various COVID-19-related challenges.

CHWs reported facing challenges when carrying out their routine work during the pandemic, including barriers to travel, inadequate PPE to feel safe, and CHW and community fears of contracting COVID-19. Very few CHWs reported shortages of contraception, drugs, or other commodities; 99.5% of CHWs reported that they had no challenges with shortages of contraception (Table 4).

One-quarter of CHWs (n=92) also reported experiencing hostility or mistreatment by the community due to their work. The most common types of CHW mistreatment were having their advice ignored by clients (54%), being refused entrance into a client's home (90%), and being yelled at or spoken to rudely in the community (34%) (data not shown).

Our data indicate that very few CHWs received infection prevention supplies regularly in their work, with just 4% of CHWs reporting regular provision of masks, gloves, and hand sanitizer. Most CHWs reported receiving these supplies "irregularly" (data not shown).

CONCLUSION AND NEXT STEPS

CHWs are a critical source of education and care for their communities during the COVID-19 pandemic, providing routine services in addition to new responsibilities. CHWs are engaged in a range of COVID-19 related activities including educating households on prevention and treatment, contract tracing in their communities, and referring clients to facilities for testing and advanced care. Our data reveal that CHWs are receiving less in-person supervision during the pandemic; however, levels of supportive supervision overall remain high.

CHWs reported various challenges such as irregular provision of supplies (masks, gloves and hand sanitizer), lack of transportation, some fear from communities, and their own fears of contracting and/or spreading COVID-19.

To alleviate challenges and provide greater support to CHWs during the pandemic, we recommend policy and program stakeholders:

1. Invest in digital supportive supervision between CHWs and their supervisors to foster regular communication.

2. Provide CHWs with masks, gloves, and hand sanitizer/ soap regularly and adequately to alleviate their own and the community's fears of contracting COVID-19.

3. Explore hostility felt by CHWs in future qualitative work.

4. Employ different channels of educating communities (CHWs, media, virtual messaging) on misinformation and misconceptions around COVID-19 and what they can do to protect themselves from contracting the virus.

5. Systematize CHW's engagement with the vaccine by building their capacity (i.e. providing training) to educate communities on the vaccine and encourage its uptake.

TABLE 4. CHW CHALLENGES (N = 370)

Percentage of CHWs reporting challenge	%
Cannot travel because of social distancing regulations	34
Do not have adequate PPE to feel safe	60
People fear CHW might spread COVID-19	66
CHW fears they may get COVID-19	84
Had shortage of contraceptives	1
Had shortage of drugs	2
Had shortage of other commodities	0.5
Public transportation unavailable	40

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The Frontline Health: Harmonizing Metrics, Advancing Evidence, Accelerating Policy project seeks to advance community health systems metrics, monitoring and learning to improve the efficiency and performance of community health worker programs. www.popcouncil.org/research/frontline-health-harmonizing-metrics-advancing-evidence