Author’s response to reviews

Title: HRH dimensions of Community Health Workers: A case study of rural Afghanistan

Authors:

Said Ahmad Maisam Najafizada (snaja100@uottawa.ca)
Ronald Labonte (rlabonte@uottawa.ca)
Ivy Bourgeault (ivy.bourgeault@uottawa.ca)

Version: 1 Date: 28 Aug 2017

Author’s response to reviews:

We thank reviewers for their comments. All the comments are addressed point-by-point.

• Reviewer #1:

General comments

The paper is well written and an interesting one to read. Its very insightful and gives a comprehensive picture and position of the CHWs in Afghanistan. I enjoyed reading this paper and no doubt it adds a lot to the existing debate on CHWs and particularly their position in the HRH discourse. In general the paper is well thought through and I commend the authors for the job well done.

• Response: Thank you

Specific comments

Introduction: The introduction just like most sections of this paper is well written, easy to read and follow. However, probably one minor issue for clarification is where the authors state that "There is also a lack of evidence on the size and distribution of CHWs and their relation to professionally regulated and recognized health workforce (such as physicians and nurses) and unregulated and unrecognized health workforce (such as traditional birth attendants and traditional healers), as CHWs often interact frequently with both". It is not clear what the authors mean by "their relation".

• RESPONSE:
We mean their “relationship with” others… and it is revised accordingly in the paper.

• I was also expecting to read more about what "an HRH perspective" is? As it is, it needs to be made clear to the reader what the HRH perspective actually is.

In the same vein, I miss the authors definition of HRH. For example, in the introduction the authors write "That is, the typical HRH focus is on professionally recognized health care providers, even though the general definition of HRH includes all people whose primary goal is to improve health?". I wish the authors could state their own definition of HRH, and make it clear which of the two definitions fits their argument i.e, is it HRH focus on professional providers or HRH as including all those who do work to improve health. As it is, its still not clear to me in the end if by discussing CHWs in relation to "others", they are not simply reinforcing the idea that CHWs may not be part of the HRH. This is because CHWs as a concept appear in itself to be in conflict with the generally recognized HRH, especially the professionally recognized workforce who in the name of safeguarding their own professional power might deliberately ignore the CHWs whom they probably think are less qualified.

• RESPONSE:

Great point. By using HRH in the title we mean the conceptual definition, as it is provided in the intro and our point is also made clear in the introduction. In our comparison, we have tried to differentiate between the two as ‘recognized’ and ‘unrecognized’ HRH. We hope it clarifies.

Methods of data collection:

The authors detail the methods of data collection used. However, where the authors mention "extensive field notes documenting observations made", it remains unclear throughout this section if observation was used as a method of data collection. If so how and what was observed. On page 16 the authors for example state "We found through field observations that in some villages where the CHWs work, traditional health providers such as religious healers" which suggests that observation as a method was used but this is not elaborated.

• RESPONSE:

The following paragraph is added on observation method:

“Augmenting the interviews, field notes were taken during site visits to document observations of health facilities for their structure, distance from villages, wards, patients, services, staff, and equipment, of the villages for the sources of drinking water and the location and the type of latrines, electricity availability, distance from clinic, and main source of income. The final field
notes included a journal of what happened during these visits, relevant statements, and the two researchers’ initial analytical reflections.”

On page 9 the authors write "In a second round of fieldwork the lead researcher shared the preliminary findings with some previous and some new participants for comment, confirmation and further data-gathering” suggesting that the study was conducted in phases (as indeed one can read from the tables, 2 and 3). But what was the reason behind conducting the study in phases? How long did each phase last?, or how do these phases relate with each other and of what value were these phases to the validity and reliability of the results. Were all these phases within the 2013/14 study period? This sentence also suggests that findings were shared at some point, as part of data collection. Is it possible to tell the readers if this was like a one on one or group or workshop or village meeting including those who never participated in the first one.

• RESPONSE:

The goal of the second round (phase) of field visit was mainly member-checking. Member-checking is a method to address the validity and reliability. The following sentences are added to address it.

“A preliminary data analysis was conducted after phase 1 before the lead researcher traveled back to the field for member checking in the second phase of fieldwork. In this second round of fieldwork the lead researcher shared the preliminary findings with previous participants, as well as with new participants for comment, confirmation and further data-gathering. Member checking is a validation procedure in qualitative methods adding value to the analysis of the raw data, as the participant takes part not only in providing the data but also in the interpretation of them. This process also helps to clarify misunderstandings, wrong information, and misinterpretations13. The second round took place between September and October 2014.”

• On page 9, the authors also write without any elaboration that "Initial analysis began during the fieldwork. Final thematic analysis was carried out by manually coding the transcripts into nodes, which were then put into sub-themes and then broader themes using constant comparison technique13”. It would be useful for the reader to know what is this initial analysis, and what does this mean? Is it part of the field notes that is partly mentioned? Or is it part of what the authors state as "A preliminary data analysis was conducted before the lead researcher traveled back to the field for member checking". How did initial analysis inform final analysis?

• RESPONSE
• The initial analysis consisted of the researchers’ initial reflection and field notes.

Results

In the presentation of results, I find a lot of detailed interpretation which I would suggest the authors can effectively use in the discussion section.

• RESPONSE:

Point taken. We have moved some interpretation into the discussion.

• Discussion

The authors need to reflect on what the limitations of the study actually imply for their results. For example, the authors write "participants’ responses may have been subject to social desirability or biases. For example, being a male, ethnic Hazara, physician and foreign-trained may have influenced data collection from different genders, different ethnicities, and different social statuses." Why should we then consider this study as a useful addition if the findings are full of biases? And when you say "being a male, ethnic Hazara, physician and foreign-trained may have influenced data collection", what do you mean exactly? In what way?

• RESPONSE:

To address reliability and validity of qualitative studies, researchers have to reflect on potential source of bias and make them explicit, and then take measures to bring them to a minimal level. To address the reviewer’s bias concern, we have explicitly written how we attempted to address those sources of bias. The last part of the limitation is modified as follows:

“Finally, participants’ responses may have been subject to social desirability or other biases, an issue commonly encountered in qualitative research. In our study, the principal researcher is a male, an ethnic Hazara, and a physician with additional foreign-training may have influenced data collection from participants who were female, and/or had a different ethnicity and social status. The researchers were aware of these potential biases and took efforts to minimize them by hiring a female research assistant for data collection, striving for a balance of ethnic backgrounds amongst participants, and continually de-briefing with the local researcher and the research supervisors over any potential evidence of bias in the study process and interpretation of results.”

• Conclusion
Are the authors suggesting that the ambivalent position/location of the CHWs is good? If yes, how?

- **RESPONSE:**

  We do not attempt to make a value judgement. We observe that they have such a position, that could be tapped as a potential strength.

Authors should also pay attention to some minor typos

- **RESPONSE:**

  We reviewed for the typos and corrected them.

- **Reviewer #2:**

  Title:

  The title is vague and need to be clarified. It is advisable not to use the term "analyzing" as it is assessment of CHW as a HRH intervention.

  - **RESPONSE:**

    Analyzing is dropped.

  Page 5, line 21: suggest not to use the term dispersing for medicine.

  - **Response:** Changed to “dispensing”

  Page 5, lines 44-60

  Page 6, line 4-25

  The points in this section is best relevant to skilled workers. How is this information relevant to marginally skilled CHWs/lay health workers? The section is not very relevant.

  - **RESPONSE:**
As reviewer #1 pointed out, our definition of HRH is all those workers whose primary goal is to improve health including both skilled and non-skilled workers. And CHWs are at some level replacing skilled workers, we found it important that the overall context was mentioned.

- Page 6, Lines 28-41

Contrary to what is presented here, the size and distribution of CHWs is well documented in Afghanistan.

- RESPONSE:

We agree that there is data at the CBHC office of MoPH on the overall size of CHWs, and we have presented some of that in our earlier works. Except for our earlier work specifically on CHWs of Afghanistan, we have not been able to find a single peer-reviewed source on the distribution of CHWs across districts and provinces in the scholarly literature.

- In addition, the mode of interaction between CHWs working strictly from a CHWs and the professional health workers of the basic package of health services (BPHS) is well known and regulated. Moreover, the categories of traditional birth attendant are not recognized in Afghanistan and CHWs are not supposed to have any collaboration with such a category. This paragraph should have concluded.

- RESPONSE:

Point taken. We have clarified it in the introduction as follows: “The BPHS policy does not recognize the categories of traditional birth attendants and healers and CHWs are not supposed to have any collaboration with them.”

Page 7

Line 15-20

It would be overstatement to suggest that the 60% coverage of BPHS is attributable "mainly" to CHWs. In fact the less conservative estimations taking fuller account of CHWs suggest that 85% of the country of covered with BPHS services. This information seems inaccurate.

- RESPONSE:

Thanks for pointing that out. The phrase is changed to “with CHWs as the first point of contact with the health system.”
Page 7, lines 22-23

BPHS is not a national program. It is a policy document suggesting the basic package of services that the government should provide through the public health sector at and below the level of district hospitals. The package includes several program components. The statement is inaccurate.

- RESPONSE:

The wording of program is changed to a ‘national initiative’

Page 7, line 56

Is the objective description of the system or analysis? As commented on the title, it is more of description rather than analysis.

- RESPONSE:

We have undertaken a descriptive analysis – providing a thick description and choosing what to describe (and not) is analytic – just as a descriptive statistical study (reporting frequencies and cross tabs are). We have altered the objective to “to offer a descriptive qualitative analysis of how CHWs function as human resources for health in rural Afghanistan, and how they interact with both formal and informal health workers in the Afghan health system.”

- Page 8, line 10

It is overstatement to say "unpack" the stated issues. The presenter actually present the already documented data from MoPH.

- RESPONSE:

Changed to examine.

- Page 8, line 20

It is unclear what is meant by the term "conducted exploratory qualitative fieldwork"; is it FGD, interviews or both?

- RESPONSE:
It is both and field observations.

- Page 9 line 7

It is difficult to justify that lack of time of the policy makers was the reason for lack of their participation. More justifiable reason for excluding this vital category should have been presented.

- RESPONSE:

Statement corrected. “Lack of time was the main reason for some policymakers not participating in the study”. Table 2 shows that we we have actually interviewed 11 policymakers at different levels in this study.

- The method section is vague and incoherently presented with certain inaccuracies (see the following comments). It is also unnecessarily long paragraphs including some of the results.

Page 9, line 23

The results should not be reported under the methods e.g. "All managers agreed to participate except one who expressed his lack of in-depth knowledge on the subject"

RESPONSE:

- Sentence removed.

- Page 10, line 54

It is not prudent to use the term army for CHWs.

- RESPONSE:

Changed to ‘Volunteer CHWs: the issue of size and distribution’

- The order of findings are not aligned with the objectives.

- RESPONSE: We have presented the findings thematically, as we have explicitly mentioned under objective section. “The specific HRH dimensions we examine focus on the (1) size
and distribution, (2) skills, (3) relationship with other formal and informal health workforce, and (4) CHW career paths.”

• Page 12 line 20-25
These are the approved MoPH Scope of Work for CHW, it would have been some interest to report where the CHWs were not allowed to provide these services.

• RESPONSE:
Good point. We have discussed the roles they were not supposed to play such as being a TBA and a CHW at the same time.

• Page 12 line 38 - 39
Please analyze the existing MoPH data (CBHC database) and present the proportion of female CHWs. It is likely that female CHWs are less than male counterparts.

• RESPONSE:
Thanks for pointing that out. We double checked the CBHC database at hand, and found that female CHWs were 49%. It is corrected in the study.

• Page 13
Lines 4-7
There is a database at MoPH to verify these findings.

• Page 12
Lines 41-54
How important are these findings? There seem to be more compelling factors to present.

• RESPONSE:
There may have been other factors. Our analysis focused on gender empowerment aspect as presented here and in the discussion.
• RESPONSE:

Thanks for pointing that out. It is 2% according to CBHC database. Corrected.

• Page 13

It is an overly exaggerated overstatement to say "They provide services in teams" as the CHWs work in solitary or binary groups. They can never work in teams.

• RESPONSE:

The word is changed to “pair”.

• Page 13

Lines 41-48

The male and female CHWs are always relatives. But, due to the nature of gender segregation in Afghanistan, they never form a functional team.

• RESPONSE:

The word is changed to “pair”.

• Page 13

Line 49-50

It is overstatement to suggest female CHWs are more active.

• RESPONSE:

It is a finding. Most participants stated that female CHWs were more active partly because of the nature of the work, a focus on maternal and child health, and partly because of gender-related other factors that we have mentioned.

• Page 14, line 56-59

Page 15, lines 4-20
It is clearly untrue that CHWs undertake combination of the extremely complex mix of services provided by a BHC. Especially, it is not correct to state that "CHWs diagnose some prevalent diseases and prescribe drugs similar to a physician."

**RESPONSE:**

Point noted. To clarify we have changed the sentence to: “CHWs detect signs and symptoms of prevalent diseases such as diarrhoea and pneumonia and prescribe basic drugs such as Co-trimoxazole (a combination of trimethoprim and sulfamethoxazole) similar to a physician; dispense some drugs and advise on the usage of those drugs similar to a pharmacist;…”

**Page 15-16**

The findings are either irrelevant to the cadre and/or the objective of the study; or overstatements

**RESPONSE:**

They are findings from the field and we describe unique health-related tasks and skills of CHWs. They may be irrelevant to the cadre as the BPHS policy would describe, but they are the realities of CHWs. Our findings are reported thematically as stated under the objective section.

**Page 17**

Lines 4-20

As per the CBHC policies, CHWs are supposed to be supervised by the CHS. Lack of their direct connection to facility staff is expected. The findings are not consistent with the policy as they were not supposed to be connected with the facility directly.

**RESPONSE:**

It is clarified that the BPHS policy have them supervised by CHSs. The rest is challenges of not being supervised by a professional.

“CHWs in Afghanistan, in accordance with BPHS policy, are not directly linked with professional health providers such as nurses or doctors, although they were a source of referral to such professionals. They are instead, linked with community health supervisors.”

**Page 18 line 35-38**
It is not correct that religious leaders do not support contraception. A recent UNFPA study shows that they are not against the FP/birth spacing services.

• **RESPONSE:**

Agreed. Some might support but some might not. In some research sites we visited, we found those perceptions, and we do not intend to generalize the findings. We would be glad to incorporate the UNFPA study on religious leaders promoting contraception (Except these dispatches, we could not find any other UNFPA report and they are incorporated


The following statements are altered accordingly:

“For example, we were told that some religious providers would never promote contraception, or deny the existence of evil spirits that cause sickness…. In 2015, Afghan government invited 500 religious leaders for a conference in Kabul to encourage them to promote family planning.”

• **Page 19-22**

The section is quite speculative and not finding of the study "Some traditional health providers may have wished to become CHWs" the section is full of such statements. It includes inaccurate and subjective statements not supported by findings or other evidence.

• **RESPONSE:**

In our study, we interviewed TBAs and traditional healers who were working as CHWs, and had focus groups members who wanted to be CHWs but did not have the support of the health council (Shuras). The statement is revised as follows:

“We also found that some traditional health providers who wished to become CHWs were not selected by the community council, explained to us as likely due to the influence of community leaders over the decision-making process.”

• **Page 22 line 51- page 24 line 12**

The whole section under career path is irritant to CHWs. CHWs are not supposed to be promoted to any other more advanced levels in their career.
Whereas we agree that Afghan CHWs, according to BPHS, do not have a career path. Yet, career development is part of an HRH perspective and we aim to describe the reasons and implications of not having a career path. To address reviewer’s comment, we have added the following findings to the career path section:

“We found that some CHWs in their 20s or younger hoped that working as a volunteer was a step to further training opportunities to become community health supervisors, midwives, nurses, or even a medical doctor. A female CHW in Bamyan Province said:

“I was told to be accepted in the midwifery program if I volunteered as CHWs.”

In fact, some CHWs have gone to become community health supervisors, nurses, and midwives. Many of the supervisors we interviewed in our study had experience as CHWs. Despite the fact that some CHWs have become paid health workforce, the Afghan CHW program does not have a standard career development route.”

Discussion and conclusion

Most of the findings are not relevant to the objective. They are also mostly speculative and based on the judgment of the presenter. For example, the study was not designed to suggest that the urban services cost more, and are medicalized, while rural settings are deprived of services stated in the paper. Therefore the findings are poorly linked with discussion and the conclusions.

RESPONSE:

We disagree with the reviewer. As noted in other responses, our findings are not speculative, and we have made efforts to ensure we have not over-stepped the limitations of the study design. We thank the reviewer for indicating some places in our manuscript where we may have done so, and noted corrections accordingly. In our discussion we intentionally attempt to compare findings from Afghanistan CHWs with the broader literature on CHWs, as HRH, including some inferences on the implications of the study, as well as acknowledging limitations of it.