HHS Public Access

Author manuscript

Health Soc Care Community. Author manuscript; available in PMC 2020 October 05.

Published in final edited form as:

Health Soc Care Community. 2018 March ; 26(2): 167–175. doi:10.1111/hsc.12488.

Community health workers' experiences of using video teaching tools during home visits - a pilot study

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Abstract

Innovations in health, such as the use of tablet computers, show promise in broadening the scope of work of Community health workers (CHWs), and play an important role in keeping CHWs and their clients up to date with advancements in health. While the use of mobile phones and tablets is innovative, the applicability of these technologies in different contexts remains poorly understood. Further, little is known about the acceptability and feasibility of the use of video teaching tools on such devices across diverse contexts. In this study, we aimed to explore the acceptability and feasibility of using tablets with teaching videos (about HIV, alcohol, nutrition and breastfeeding) to support the health promotion efforts of 24 CHWs who work with pregnant mothers and mothers of young children in an urban township in South Africa. Between November 2015 and May 2016, we conducted focus groups and identified four key themes (with several sub-themes) that demonstrated factors related to the acceptability and feasibility of these devices and their content. Focus group transcripts were analysed thematically using qualitative data analysis software. The findings indicated that while the devices contained several supportive features (such as lightening the workload, and stimulating interest in their work) they also contained several restrictive features (safety and confidentiality). CHWs considered the video content an important tool to engage not only their clients, but also family members and the community at large. Issues surrounding safety, privacy and confidentiality of using these devices require careful consideration prior to implementation in large scale studies. Further, stigma associated with household visits by CHWs and the nature of their work also need to be addressed by researchers and programme implementers. Overall, CHWs deemed the devices and the video content an acceptable and feasible means with which to provide health promotion and education amongst their clients.

Keywords

Community health workers; tablet devices; mHealth; video; qualitative

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Introduction

In low- and middle-income countries (LMIC), healthcare facilities are under considerable strain (Narasimhan et al., 2004). Since the early 2000s and in response to the Millennium Development Goals (MDGs), lay healthcare workers (now known as community health workers (CHWs)) were mobilised in an effort to provide primary health care services at community level. Indeed, CHWs play a vital role in the delivery of primary health care and disease prevention in many LMIC (Bhutta, Lassi, Pariyo, & Huicho, 2010; R. Braun, Catalani, Wimbush, & Israelski, 2013; Singh & Sachs, 2013).

Despite this, many CHWs receive inconsistent supervision, monitoring and training beyond their initial appointment (Bhutta et al., 2010; Hill et al., 2014). The high variability in program quality complicates the extent to which CHW effectiveness is assessed across various settings (Odendaal et al., 2015). Efforts to maximise the impact of CHWs in the absence of this support has led to the application of new technologies to enhance the quality of care and broaden the scope of services that CHWs provide (R. Braun et al., 2013; Labrique, Kirk, Westergaard, & Merritt, 2013). Mobile technology includes cell phones, tablets (e.g. iPad or Samsung Tablet), smartphones (e.g. iPhone), and personal device assistants (PDAs) (Free et al., 2013). These devices are easy to carry and in the case of tablets, have the advantages of a larger screen size than cell phones, a longer battery life than laptops, and a substantial storage capacity for educational content (Pitt, Berthon, & Robson, 2011). Tablets and mobile devices therefore provide CHWs with a means with which to access accurate and correct information during client consultations.

These technologies are expected to deliver health promoting messages efficiently, effectively, and economically (Zhang, Zhou, Briggs, & Nunamaker, 2006) by allowing users to share health videos and photos, send short message service (SMS) text messages, conduct and administer surveys, search the internet, or collect data. Nurses using tablets in under-resourced settings have been shown to make fewer errors, readily accept the tablets, and often preferred tablets to pen and paper (O'Mahony & Wright, 2014). In India, Ramachandran, Canny, Das and Cutrell (2010), used short videos on cell phones to help persuade women in the community to utilize healthcare services, and to help local CHWs (referred to as Accredited Social Health Activists) to improve their performance in motivating women to seek these services. The creation and use of videos helped to engage women in dialogue and had positive effects on health worker motivation and learning. Similarly, other interventions using these technologies have shown to significantly improve health literacy and health-related outcomes in a variety of settings, for different diseases, and with diverse samples (Aranda-Jan, Mohutsiwa-Dibe, & Loukanova, 2014; Jacobs, Lou, Ownby, & Caballero, 2016; Mahmud, Rodriguez, & Nesbit, 2010).

Despite acceptability of technology in a variety of health care settings, challenges remain. The limitations of new technologies include structural barriers and lack of personal motivation (Chaiyachati et al., 2013) and resistance from recipients due to limited education, training and social status (Ramachandran, Canny, Das, & Cutrell, 2010). There are also structural limitations to the use of tablets by CHWs such as poor access to Wi-Fi or cellular networks, poor internet connectivity, lack of physician or CHW acceptance, insufficient

training, and inadequate management by the research team, IT department, or clinic (Yu, Wu, Yu, & Xiao, 2006), inadequate clarity of pictures, delayed video streaming, poor functionality of the application, and a lack of translation to local languages (Sureshkumar et al., 2016). Although eHealth technology has high initial costs, there is evidence of long-term cost-effectiveness (Blaya, Fraser, & Holt, 2010).

Available evidence suggests that CHWs can use tablets to improve health literacy and to reduce costs of health interventions. Further, there is evidence to suggest that it may be worthwhile taking this method of video learning into the community on such devices (Ramachandran et al., 2010). Most of the research assessing the acceptability and feasibility of tablets consists of randomised controlled trials, which typically do not explore individual experiences (Abernethy et al., 2009; Aronson, Plass, & Bania, 2012). Understanding the personal experiences of users of these devices and the video content on them within their specific contexts is important if expansion of these devices and video content is to be considered in the future. Context-specific information offers valuable insight into unexpected issues encountered in the field, and an understanding of whether these devices would be accepted at all.

In this study we aimed to determine the acceptability and feasibility of using tablets with video content related to HIV, alcohol, nutrition and breastfeeding amongst CHWs who conduct home visits with pregnant women and mothers of young children in a township community.

Participants and methods

Design

This study forms part of a formative mixed-methods pilot investigation, using both quantitative and qualitative methods, to assess the acceptability and feasibility of using videos and tablets in CHW-home visit settings with pregnant women and mothers of young children. As part of the larger investigation we created a collection of short, illustrated videos based on an evidence-based health promotion curriculum. The video content was mainly focused on maternal-child health promotion. For example, there were illustrative videos on the tablets about nutrition in pregnancy and early childhood, breastfeeding, alcohol avoidance in pregnancy, prevention of transmission of infectious diseases, and early child development. The same standardized set of illustrated video content was available on each tablet. In this paper we report on the qualitative findings aimed at determining the feasibility and acceptability of using tablets with educational videos from the perspectives of CHWs in a township community.

Context

The study took place in Khayelitsha, a peri-urban settlement approximately 35km from Cape Town. Close to half a million people live in Khayelitsha. It is estimated that 38% of residents are unemployed and 45% reside in low-cost housing (City of Cape Town Strategic Development Information and GIS Department, 2011).

The Philani Health and Nutrition Project (non-government organisation) has been implementing a community based health outreach program in Khayelitsha for more than 30 years, through the deployment of CHWs (also referred to as Mentor Mothers) (Rotheram-Borus et al., 2011). Philani CHWs are paraprofessional members of the community that were carefully selected by local leaders and key stakeholders following appropriate training and supervision (Rotheram-Borus et al., 2011). CHWs were considered for selection on the basis of their positive role model status in the community. Training lasted for a period of two months and was guided by a comprehensive intervention manual (Rotheram-Borus et al., 2011). The training focused on equipping CHWs with skills to problem solve everyday issues using their experience as well as drawing on their knowledge of available resources. The CHWs' caseload is predefined and circumscribed to neighbourhoods deemed at high risk for health problems. Philani CHWs visit pregnant women and mothers of young children in their homes where they deliver a variety of health messages. Typically these health messages consist of content focused on nutrition in pregnancy and early childhood, breastfeeding, alcohol avoidance in pregnancy, prevention of transmission of infectious diseases and early child development. In addition to this, CHWs conduct routine growth monitoring of children under 5 years and refer malnourished children for follow up services. Each CHW visits approximately four community members each day to counsel them on health promoting behaviours (i.e. deliver health education on HIV, alcohol and nutrition), with a total caseload of 50–80 families. Data (e.g. on child growth and nutrition status) collected from the community members was overseen, captured and stored by Stellenbosch University.

Participants and procedure

We invited a randomly selected group of 24 CHWs from Philani to take part in the study. All CHWs participated in a "before" focus group on how tablets and video content might influence their work. Following training on the tablets, the CHWs then used the tablets for six weeks during their home visits. Then each CHW participated in an "after" focus group about their experiences using the tablets. The 24 CHWs were divided into two staggered groups of 12 CHWs due to a limited number of tablets for the pilot study. While Group 1 used the tablets for six weeks, Group 2 used routine methods. While Group 2 used the tablets, Group 1 returned to routine methods.

Data collection

CHWs in both groups were invited to take part in focus groups (between November 2015 and May 2016) and were informed that the purpose of the study was to explore the acceptability and feasibility of the use of tablets during home visits and the video content on tablets compared to usual methods of delivering health messages. Focus groups were an appropriate methodology in this study as the group dynamic allowed the facilitator to explore agreements and differences. Focus groups were conducted at the convenience of CHWs and took place in a private space at a community organisation or at the research office in Khayelitsha. Focus groups were conducted in the local language, isiXhosa. Focus group facilitators were qualified and trained data collectors employed by Stellenbosch University with several years of experience in conducting interviews and focus groups. Focus groups were guided by a semi-structured questionnaire (that explored barriers,

attitudes, reactions, appropriateness, and preferences surrounding the tablets and video content). Prompts included questions such as “What are your impressions about how using tablets might help or not help the work you do?” in the first focus group, and “In what ways could the tablets be improved” in the second focus group. Focus groups were audio-recorded with the permission of participants, and transcribed verbatim. Following initial transcriptions, transcripts were checked for quality by the focus group facilitators and any inaccuracies were corrected in consultation with the transcribers.

Data analysis

For the purposes of systematic organisation, coding and transparency in the analysis process, focus group transcripts were imported into ATLAS.ti version 7 (www.atlasti.com) a computer assisted qualitative data analysis software programme. Two experienced qualitative researchers coded the transcripts, one using ATLAS.ti (BC), and the other manually (HK). Within ATLAS.ti, the transcripts were coded using steps consistent with Thematic Analysis (TA) (V. Braun & Clarke, 2006). Coded transcripts in ATLAS.ti were then compared and checked against manually coded transcripts. Through a process of peer-debriefing authors (MT, MA, NM and IL) ensured the credibility and trustworthiness of the coded data by reading and re-reading several iterations of the findings, and providing insight into how the semantic themes could be abstracted to more latent themes. Themes were reviewed for coherence, through examination of all coded extracts for each theme, and for whether themes accurately reflect the meanings evident in the data set as a whole (V. Braun & Clarke, 2006). Final key themes, made up of clusters of similar themes, were selected on the basis of their prevalence, richness and the importance placed upon them by participants. The analysis process was made as transparent as possible through study researcher’s annotations and notes, from initial thoughts, to clusters of ideas, to themes (Smith, Flowers, & Larkin, 2009).

Ethical considerations

All CHWs who take part in the focus groups were provided with a consent form and an information sheet, and each gave consent to participate. The consent form specified that their participation was entirely voluntary, and that they were free to withdraw from the study without consequence. Further, participants were assured that all the information they provided would remain confidential, and that the risks of taking part were minimal. The information sheet clearly outlined the nature, purpose, objectives and procedures of the study; as well as information on how to contact the research staff to discuss any aspect of the study after the interview. This information sheet also provided the contact details for mental health services if participants felt the need to use them. Both the consent form and information sheet was explained and discussed face-to-face with the prospective participants in their preferred language. The focus group facilitator paused at regular intervals during the consent procedures to ask if there were any questions, and to clear up any misunderstandings related to the study procedures. Participants were asked to sign the informed consent form and were able to keep a copy of the consent form and the information sheet. The research protocol was approved by Stellenbosch University’s Health Research Ethics Committee (Ethics Reference: N15/10/115) and Stanford University’s IRB (Exemption, Protocol ID: 34693).

Findings

Sample

Our sample consisted of 24, female CHWs between the ages of 25 and 60 years, employed through the Philani Health and Nutrition Project.

Results following thematic analysis

As seen in Table 1 below, we identified four overarching themes with several sub-themes that captured CHWs experiences of tablets use during their home visits. Each of these are discussed below, and supplemented with relevant quotations.

Supportive features of tablet use

Promotes importance of work—CHWs stated that before the introduction of the tablets, they felt as though their health promotion messages were not taken seriously and perceived clients' disinterest in the content as a form of informational disregard:

> …because most of the parents undermine our work, they would say we are there to talk about the same thing over and again. (CHW 11)

CHWs reported that in their opinion the tablets helped to convey a sense of importance about their work, and that this boosted confidence and morale:

> I like it because it uplifts our work. It shows people how important is our work. (CHW 3)

Another CHW explained that using the tablet provided her with a sense of dignity about her work:

> I do not want to lie, I became very proud, I saw that it is now that I am working, I saw my dignity because there is that thing (the tablet) […]. (CHW 5)

Administrative ease—CHWs experienced tablets to be effective educational and administrative tools, and to be far more time efficient compared to their usual methods. CHWs stated that the use of videos allowed for them to attend to administrative tasks and note-taking whilst their clients engaged with the videos:

> You enter a house and you would open a folder and we also have the household assessment forms, you have to do it and I think it will minimise the time that you spend in one house. (CHW 2)

While CHWs reported less time spent in households, they experienced their interactions to be more meaningful. For some CHWs, being able to show videos to their clients as opposed to talking was especially useful on days they felt tired. As such, CHWs stated that tablet videos ensured that their interactions with clients on such days were not compromised in any way:

> I will just open it and show her a mother that is breastfeeding- there are days where I would not have the strength to talk just like today. When I do not have the strength to talk, I just take out the tablet and just explain here and there. (CHW 6)

CHWs enjoyed the convenience that the devices offered, and hoped that in the future they would have internet and email access on the tablets, and that all of their paper work would be compiled in the tablet. Some were concerned that they tablets would eventually be taken away:

> "We would not feel right." And, "It would be painful".(CHW 2)

Restrictive features of tablet use

Safety concerns—CHWs agreed that they were concerned about the safety and use of tablets in some of the communities and households they visited:

> I was also afraid because of the places that I go to. The places that I go to criminals will be looking at me while they did not mind me before. (CHW 10)

Some CHWs stated that they often chose not to use tablets during household visits when unfamiliar household members were around or when households were crowded:

> We had to make sure that you look at it in a house that has people that you know you trust, your clients but if you get out and go to another house. If you arrive in that house and it is full with many people you cannot use it. You cannot be able because they will target you […]. (CHW 7)

CHWs reported that in some instances clients themselves would recommend avoiding certain areas and in other instances asked CHWs not to use the tablets during visits as a means to protect them. The protective disposition of clients towards CHWs demonstrated the good working relationships and level of rapport between CHWs and their clients. CHWs made suggestions to ensure the safety of the devices as well as themselves, including that tablets become password protected, contain tracker devices or theft alert protocols, and that they wear bullet proof vests to physically protect themselves. The suggestion of such measures was testament to the discomfort and unease CHWs associated with working in many of the communities.

Confidentiality concerns—Several CHWs stated that their clients would require a proper introduction to the tablets, to address issues of confidentiality and prevent distrust towards CHWs. CHWs reported that establishing proper trust with their clients was necessary in order to successfully expose their clients to new technologies. Establishing trust and reassuring clients of confidentiality was especially important in the context of stigma. CHWs reported that some people in the community knew little of what their work entailed and believed only individuals living with HIV received visits from them:

> Most of the time my sister, they do not know what is it that we do, they do not know our work. They tell themselves that we visit people that are HIV positive. (CHW 6)

Several CHWs reported that some clients worried that the devices were being used as voice or video recorders:

> I thought that they (clients) were going to think that you will record them and take pictures of them. I thought they were going to say that as we drink this way […], you are now going to record us and take pictures of us. (CHW 10)

Tablet training experiences

Length of training sessions—Overall, CHWs were excited about the addition of this new technology to their lives, but some admitted to being hesitant about the extent to which they would be able to use the devices effectively. Prior to receiving tablet training CHWs stated that they experienced some anxiety about using the device and that the training was expected to alleviate a lot of the anxiety. For many of the CHWs, their children assisted them with becoming familiar with the tablets different functionalities. This was appropriate given that the tablets in this study did not store confidential patient data. Part of their concern stemmed from the fact that they felt as though the training sessions were short, and they needed to practise with the tablets at home. The following sentiment was shared amongst several of the CHWs:

> By the time it was given to me, I did not know where to start with it, I was just taking it because it was said here it is. (CHW 6)

> I can also say that it [the tablet training] was not enough. I wanted more than the one that we were given. They just gave us a little knowledge and I thought that it was because the tablets just arrived, then in time there would be something that they will do. (CHW 10)

For many CHWs feeling confident about using the devices was important as some reported feeling ashamed and embarrassed making mistakes with the tablets in front of clients, especially in the beginning:

> I think that she (referring to another CHW) undermined herself in front of a clients and saw that the training was not enough. (CHW 1)

Privilege to work with expensive technology—Some CHWs stated that they felt immensely privileged to be working with the tablets, and this contributed to their self-worth and confidence in their roles:

> I never once of the thought I would use it but now because of its price when you look at the shops but now it makes me special even at home I can plan because I plan my work with because I know now when I put my folders here and my cases, I know where to click when I am using it. It makes my work easy, it is helpful. (CHW 6)

Video content as community engagement tool

Stimulates interest in material—Most CHWs reported that they felt the attention of their clients wane with time. They described their clients becoming bored with their verbal messages and felt that video messages assisted them in recapturing clients' attention, and maintaining good rapport:

> The tablet is what attracts attention from her because sometimes I would get there and she would be busy doing her washing and not care about your work. (CHW 4)

Recognising that their clients became bored with repetitive information, some CHWs reported that video messages were also not repeated in households where they had seen visible integration of health promotion messages into clients' daily routines. However, this was not always taken for granted:

> [With] others there would be no need [to show them the video again] because what you are saying, they are already doing what you are telling them. Others for example, would pretend that they are doing it in front of you but when you get out they would do another thing. (CHW 5)

For the most part, CHWs believed that their clients' renewed interest in their work was as a result of being able to hear the messages from a different source. CHWs describe that in the Xhosa community, seeing information inspires much more trust than hearing information:

> We believe in seeing, you would say all that to them but they would not believe, but when they see it, they will believe. (CHW 1)

When clients could learn by seeing rather than listening, the tablets were able to increase interest in and credibility of the CHWs' messages. CHWs reported that the videos provided their clients with an additional opportunity to hear the messages again, and that in the long term this improved recall of the information:

> In the beginning we would go in the community and tell them that mom, as you are pregnant you would have to eat three different types of food and you would realise that she does not even know the different types of food and she would tell you that she heard when it was talked about in the clinic but she did not hear it because there was a noise there. (CHW 5)

Further, CHWs reported that they had observed their clients become interested in the video content and that this not only invoked a curiosity within their clients, but also other household members.

Health promotion messages spread in the community—Some CHWs reported that they had observed that the content of the video messages also become a talking point amongst members of their family and community as clients shared what they have learnt with others:

> When you have shown only one mother, she will expand and tell the others and say hey, I saw something and I did not know about the thing that I was doing, that I was doing wrong things. (CHW 1)

> When the father saw that, he jumped and stood in his feet. He said that I have been watching you talking in the house and I would sometimes leave you and go to the bedroom but today you asked me to watch too so that means that what you are saying are things that are building and they want to be given attention because from the way that you are telling us and even show us that alcohol is wrong and has consequences to the child and yes this is my child and is my blood. (CHW 2)

Discussion

The aim of this study was to explore the acceptability and feasibility of using tablets and video content amongst CHWs who provide pregnant women and women with young children with health education in the community. We identified key themes relating to 1) the supportive features of the devices, 2) the restrictive features of the devices, 3) their experiences of being trained to use the devices and 4) the importance of the video content as a tool to engage the community on health promotion.

Collectively, our findings suggest that CHWs deem tablets and health education videos an acceptable and feasible means with which to engage women in the community. Further, these findings provide important insights into how CHWs perceive their roles in the community, and the ways in which technology seemed to facilitate a renewed sense of purpose in their role. In many LMIC a considerable demand is placed on CHWs to serve as the bridge between primary healthcare and the community (Bhutta et al., 2010; Singh & Sachs, 2013). Often, out of necessity, CHWs assume various roles within their communities - reaching far beyond the initial training they received. Even with rigorous and well-tailored training programmes, such as that offered by Philani, CHWs in this study still felt at a relative disadvantage to establish themselves and locate their purpose within the healthcare system. In this study, CHWs reported that they perceived their clients to question their role and purpose, but that the use of these tablets reaffirmed that they were important and were able to retain the attention of their clients.

Other studies have also shown that mHealth technology (such as mobile phones) promotes self-efficacy and confidence in CHWs (Lee, Chib, & Kim, 2011). However, it should be noted that in the study by Lee et al., (2011), self-confidence in using cell phones as part of CHWs work was largely associated with personal familiarity with the devices. In this study, CHWs reported that they did not feel entirely competent in the use of tablets following training. Incorporating new technologies assist CHWs in programs where supervision and training may fall short. However, proper training on the devices is required for proper use. In this study CHWs shared mixed emotions on the nature of the training that they received. While the CHWs stated their preference for tablets, they did not feel confident in their ability to use the tablets during home visits without much more practice and training. CHWs reported relying on their children to further familiarise them with the device, a strategy that has been used by CHWs in other studies (Zurovac, Talisuna, & Snow, 2012). In this study confidential patient data was not stored on the tablets. However, storing patient data in this way is not uncommon and while such strategies may place the privacy and confidentiality of patient data at risk (Labrique et al., 2013), encrypting patient data with strong passwords provides a potential solution to this problem in the future.

Maintaining good relationships and rapport with clients is key to the effectiveness of CHWs in these settings. In this study CHWs stated that individuals in the community associated visits by them as visits to persons living with HIV. As previously mentioned, the Philani Health and Nutrition Project has been operating in this community for more than 30 years and focuses predominantly on child health and nutrition. CHWs typically carry weighing scales and other tools to facilitate home visits and the visibility of these devices have

deterred some stigma concerns. Establishing supportive networks and social capital within a community, are necessary to minimise stigma surrounding illness and attending healthcare facilities. Encouragingly, CHWs reported that the video content became a talking point amongst members in the community. This receptiveness to the content and willingness to share information, may in the long run reduce suspicion about the nature of their work.

While the reduced time in the field and administrative ease offered by these devices was valued by CHWs in this study and others (R. Braun et al., 2013; Mahmud et al., 2010), it was concerning that tablets in this study were interpreted by some as a means to avoid interaction- even though this was only referred to by CHWs when feeling tired or fatigued. This reliance on technology to engage clients, essentially contradicts the purpose of the devices, as they are meant to assist with building relationships, improve the quality of care and broaden the scope of services CHWs provide (Florez-Arango, Iyengar, Dunn, & Zhang, 2011).

There is no doubt that the facilitators associated with using these devices routinely, far outweighed the barriers. However, issues with safety, privacy and confidentiality cannot be ignored. For researchers considering larger studies using these devices, especially within contexts similar to that in which this study took place these barriers will need to be addressed. At the level of safety, CHWs reported that carrying the devices rendered them at risk for theft. Theft of devices is not only a traumatic experience for the individual involved, but also comprises the confidentiality of the data on the devices (Labrique et al., 2013).

We acknowledge several limitations with this study. Firstly, given that CHWs were all from the same NGO and interviewed about their work, there may have been potential social desirability bias in the extent to which they reported on their experiences of their work and training. Further, we did not elicit data from the clients themselves on their perceptions and acceptability of the devices. The data in this study emanates from a small sample of CHWs, trained using well-established models of supervision and mentorship. Despite these limitations, we believe the insights about the use of tablets by CHWs included in this study would be useful considerations when implementing tablet programs in other communities.

Conclusion

mHealth technologies offer considerable support to CHWs to improve the scope and quality of services they offer. While the effectiveness of these devices are not yet clear, qualitative studies such as this one offer important insights into the barriers and facilitators associated with using these devices in different settings amongst individual’s with different skill sets. In this study, tablets and their associated health-promoting video content were an acceptable and feasible method of health promotion and offered CHWs a renewed sense of purpose in the job role and self confidence in their work, reduced time in the field and offered administrative ease. Issues of safety, privacy and confidentiality were salient and require considerable attention by researchers and programme implementers if these devices are to be used at a larger scale. While the purpose of the study was to determine acceptability and feasibility of these devices by CHWs, we think it important to state that improving the quality of the service provided by CHWs to their clients is essential. This quality can only be

improved if CHWs receive proper training on the devices, and continue to nurture relationships with their clients in these settings.

Acknowledgements

We would like to thank all of the participants who gave of their time to be part of this work. We would like to acknowledge Professor Charles Prober at the Stanford University School of Medicine for his contribution to funding this work. We would also like to thank Dr Jackie Stewart for her contribution to this work.

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What is known about this topic

- Community health workers (CHWs) play an important role in providing basic health services to individuals in poorly resourced communities.
- CHWs take on various roles to meet the needs of the community, and technological devices seem to hold promise in improving the services they provide.
- The acceptability and feasibility of using tablets from the perspectives of CHWs is still poorly understood across various settings.

What this paper adds

- Tablets and health promoting and educating video content are an acceptable and feasible means with which to facilitate home-based visits by CHWs.
- Technological devices such as tablets improve CHW morale and offers administrative ease during home visits.
- Such devices need to be used with caution in certain contexts in order to protect the safety of their users.

Table 1.

Themes and sub-themes

Supportive features of tablet PC use	
	Promotes importance of work
	Administrative ease
Restrictive features of tablet PC use	
	Safety concerns
	Confidentiality concerns
Tablet PC training experiences	
	Length of training sessions
	Privilege to work with expensive technology
Video content as community engagement tool	
	Stimulates interest in material
	Health promotion messages spread in the community