RESEARCH ARTICLE

Personal Values of Being a Long-term Peer Health Educator Cadre for Elderly and Reproductive-age Women Communities: a Qualitative Study

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Accepted: 2 April 2019
DOI: 10.23886/ejki.7.10735.

Abstract

Maintaining health cadres in a long term program is important as well as challenging. A collaboration of university, financial support institution (BTPN) and international NGO (Grand Aides) has developed five years community empowerment, named Daya Program to promote community health education. The program trained new workforce of customer volunteers to perform peer health education for elderly and reproductive age women communities in nine cities across Indonesia in 2012-2017. This study aimed to evaluate personal value of lay elderly and reproductive age women for being a long-term peer health educator cadre in Indonesiaand explored health cadres' perceived benefit, motivation and challenge. To this end, semi-structured focus group discussion with twenty cadres and interview with nine area supervisors were conducted. Thematic analysis was employed to analyse the data collected. Daya Program benefited not only to the community but also to cadres and their family. Beside promoting financial benefits, health cadres and their family perceived social incentives for their status of being peer health counsellor in the community such as pride and respects from their neighbourhood. Cadres' skill in performing some health screening like blood pressure check and self-breast examination were highly appreciated by the communities. Cadres feel trusted and meaningful because client openly discuss sensitive health issues like breast lump among them. Such incentives had been external drivers for the cadres to actively involve in the long-term program. Cadres emphasized perceived respect from the community as important reason, beside financial benefit, that maintain their contribution in long-term. Therefore, these lessons might be important for community health program drafter in designing long-term peer health development program.
Keywords: *personal value, health cadres, community empowerment program.*

Persepsi Manfaat dan Motivasi Kader Penyuluh Kesehatan bagi Komunitas Lansia dan Perempuan Usia Produktif: Sebuah Studi Kualitatif

Abstrak

Menjaga motivasi kader kesehatan dalam pelaksanaan program pemberdayaan masyarakat jangka panjang merupakan hal penting namun penuh tantangan. Kolaborasi universitas (Universitas Indonesia), bank (BTPN) dan lembaga internasional (Grand Aides) telah merintis program pemberdayaan masyarakat selama lima tahun bernama Program Daya yang berfokus kepada promosi kesehatan melalui edukasi kesehatan kepada masyarakat. Program ini melatih sukarelawan nasabah bank untuk melakukan edukasi kesehatan bagi komunitas lansia dan wanita usia reproduksi di sembilan kota di Indonesia di periode 2012-2017. Studi ini bertujuan untuk mengevaluasi persepsi manfaat dan motivasi pribadi kader perempuan lanjut usia dan usia produktif yang telah menjadi kader pendidik dalam program ini selama 5 tahun. Studi ini menggali persepsi akan manfaat yang didapat, motivasi, dan tantangan yang mereka hadapi. Oleh karena itu, dilakukan diskusi kelompok terarah semi-terstruktur kepada dua puluh kader dan wawancara dengan sembilan supervisor pelaksana di masing-masing. Analisis tematik digunakan untuk menganalisis topik-topik yang dikumpulkan. Selain mendapatkan manfaat finansial, kader kesehatan merasakan manfaat sosial karena meningkatkan status sosial dan apresiasi dari masyarakat sekitar lingkungan mereka tinggal dan hal itu menjadi kebanggaan bagi mereka, Keahlian kader dalam melakukan pemeriksaan kesehatan seperti pemeriksaan tekanan darah dan pemeriksaan payudara sendiri sangat dihargai oleh masyarakat. Kader merasa dipercaya karena klien secara terbuka mendiskusikan masalah kesehatan sensitif yang mereka alami seperti benjolan payudara. Hal tersebutlah yang terutama menjadi pendorong eksternal bagi kader untuk terlibat aktif dalam program jangka panjang selain manfaat finansial. Oleh karena itu, pembelajaran ini penting bagi penyusun program pemberdayaan masyarakat dalam merancang program jangka panjang khususnya dalam hal edukasi kesehatan.
Kata kunci: *manfaat dan motivasi, kader kesehatan, program pemberdayaan masyarakat.*

Introduction

Health cadres (HC) play a prominent role in assisting primary health care level such as to perform promotive-preventive program in the community. The promotive-preventive program had been given a priority than curative program. In addition, HC, also known as community health workers (CHWs) is considered as agents to provide education and simple healthcare interventions to their own communities, whilst ensuring community participation and action.[1] The HC who include lay people and is a part of community perform voluntarily work for the community where they live in, receiving less training than formally trained health workers and also supported by the health system.[2]

The voluntary aspect in cadre's work yield difficulties in maintaining their involvement in a long term program. HC are required to have decent motivation and gain benefit from the program in order to maintain their participation in promotive-preventive program. More specifically, in peer health education program, when cadre is expected to obtain new health knowledge and transfer it to their communities.

Elderly and reproductive age women are example of prioritized and targeted communities for promotive-preventive program. They are communities that prone to preventable diseases like hypertension in elderly and breast cancer in reproductive age women. However, empowering lay people to be peer health educators is challenging, especially in elderly for their limited cognitive ability such as low ability to memorize new trained health topics. Recruiting reproductive age women to be peer health educator might be also challenging due to lower education background and less focus while doing HC activities. To authors' knowledge, exploration of HC's personal value in elderly and reproductive age women group is still limited but very important as it may depict their personal value as an individual, part of their family and their community. Therefore, this study aimed to evaluate personal value of lay elderly and reproductive age women for being a peer HCs in Indonesia. Sources of HC's motivation were identified at the individual, family, community level besides the incentive aspect.[3]

Methods

The researchers conducted focus group discussion (FGD) on 20 voluntary cadres that represented 9 areas. FGD was located in Jakarta, March 2017 and divided into two groups of discussion. The first group consisted of 10 HC for the elderly community (ED) and the second group were 10 HC for the reproductive-age women community (RAW). The FGD led by a moderator, asked six questions in a row and all the participants had the same opportunity to give their answers. The questions aimed to gain information related to HC's personal valuesand benefits on individual, family and community level. Moreover, the discussions were done to identify the cadres' opinion on the most useful activities for the community and what challenge the cadres faced as well as the future follow up when the program wasfinished. Area supervisors (AS) were interviewed separately after the FGD to confirm triangulation of the emerging statement from the FGD.

All participants used an information sheet to get the study description clearly. Furthermore, written consent was requested. It took approximately 2 hours and 30-45 minutes to do respective recorded FGD and interviews. Audio record wasverbatim transcripted. Transcripts were explored through multiple readings to confirm familiarity with the data. The transcripts were coded and systematically analysed. As key themes emerged, a framework of theme was developed and descriptive quotes were coded under each theme. Meanwhile, to strengthen the study, data triangulation was taken from cadres, area supervisors and two communities: elderly and productive age women.

Results

Characteristics of the HC are summarized on Table 1. Overall 20 HC were involved in FGD. Most of the HC are females (90%) and their last education are high school (75%). Age proportion of HC is equal for each group. Based on the area, most of them come from West Java province (55%). Meanwhile, nine supervisors consisted of 3 males and 6 females were interviewed separately after FGD. The supervisors' educational background are medical doctors and only one supervisor is more than 55 years old.

Based on the 6 questions delivered to the HC, 5 aspects of their personal value were resulted: individual level, family level, perception of HC about how the community value the benefit, the challenge and their future plan.

Table 1. Characteristics of Health Cadres Involved in FGD

Characteristic of Health Cadre	Number (n=20)	%
Sex		
Male	2	10
Female	18	90
Area		
Banten Province (Serang, Pandeglang)	6	30
West Java Province (Depok, Bekasi, Karawang, Sukabumi, Cianjur and Cirebon, Kuningan)	11	55
East Java (Probolinggo, Pasuruan)	3	15
Age group		
20-55 yo	10	50
above 55 yo	10	50
Level of education		
High school	15	75
University	5	25

Perceived Benefit from Individual Level

Increasing Knowledge and Skills on Some Diseases Early Detections

The benefits of being HC, as most HC admitted, are it could develop the cadres' knowledge on hypertension, blood pressure interpretation result such as systolic and diastolic and it educated them how to detect and prevent themselves from becoming hypertension. They also could educate their closed family and clients about it.

"The training gives me knowledge regarding on healthy life, how to be free from obesity and how to do balanced diet. I try to apply those knowledges by eating more vegetables now" (HC 18, female, RAW)

"Now, I know more about systolic and diastolic as part of blood pressure, about the meaning of the results and I can explain the results in details to the clients" (HC 9, male, ED)

"I can use my skill on how to examine blood pressure, to check the condition of my family member with some condition like headache" (HC 1, female, ED)

"By doing activity as a HC, I don't only maintain my social interaction but also my memory as well especially when I give education" (HC 10, male, ED)

"Having known such knowledge, one of my cadres from ED group, Mr X, who had hypertension was aware to consume anti-hypertension drug and tried to lower his salt consumption" (area supervisor/AS 3, female)

Gaining Pride and Self Confidence from Social Status Recognition

Some benefits of being the HC were increasing social status recognition when the people know them better and making life more meaningful when their services were awaited.

"I feel my life is more meaningful and people looked at me as a role model. So actually it makes me excited to apply the healthy life style" (HC 8, female, ED)

"People, they did not quite recall my name, but they called me Bu Kader (cadre), and I can sense that my visit to their group was awaited and missed" (HC 11, female, RAW)

"Pensioners in the bank look after them and questioned where the cadre were, if they had training in Jakarta" (AS 1, male)

Financial Support from the Program

Most cadres are able to allocate some money they earned from the program to support their family needs. Moreover, they also had intangible benefits from the community recognition, people come to consult or to check blood pressure afterwards, buy something from cadre's business in their houses.

"From cadre fees, I can help my husband to fulfill financial needs" (HC 20, female, RAW)

"The amount was not so big, but at least I can support my grandchild education fee" (HC 9, male, ED)

"I was known as HC and people used to come to my house to check their blood pressure and then buy something from my store, it's just got co-incidence benefit" (CH 14, female, RAW)

Meanwhile, one of them did not think of money as everything since she loves doing her job.

"Money can come from any other sources, not only from this program, I did it because I enjoy doing this" (HC 18, female, RAW).

Perceived Benefit from Family level

Recognition as Role Model of Healthy Life Style Behaviour in The House

The cadres were more well known, as a role model for healthy and active lifestyle at home. They try to apply practical knowledge related to disease prevention gained from the training e.g. hand washing, routine blood check monitoring, etc.

"Having got information about how to wash hand properly, I show my husband and children how to do it. I bought liquid handwash soap and they actually do the hand wash properly and regularly. (HC10, female, RAW)

"...I managed to convince my husband to

renovate house a bit, add more ventilation so the air flow better and we clean the house regularly.." (HC 3, female, RAW)

The Secure Feeling of Having Someone in the House Who Knows Better When to Refer and Who to Contact if f Family Members Got Sick

Having trained concerning on the protocol of self-managed some health complaints, the cadres can calm their family and do first examination such as blood pressure check.

"When my father got headache and he was afraid of his blood pressure, I could immediately check his blood pressure. Finally, he became relieve knowing the result afterwards" (HC 7, female, ED)

"I could refer to the self-managed guidance to give first management when my family got sick. As the result, it relieved them" (HC 1, female, ED)

Perceived Benefit from Community Level

More Respects to Blood Pressure Examination Ability

HC perceived more community appreciation on blood pressure exam and the ability to do it. Their convincing skills contributes easiness to administer health education. More people believed in the health cadres, willingly listened to their suggestions and consulted more about their health problems after getting blood pressure check.

"Blood pressure examination was the most benefit activity for the community. Some people did not realize they had hypertension until they got the result" (HC 1, male, ED)

"When I came to reproductive age women group, I started with blood pressure check. Based on the result, I gave them relevant advice. It was easier for me to start my education session afterwards" (HC 4, female, RAW)

Respect due to the Practical Knowledge of Relevant Health Problem

Once attended some trainings, HCs had capacity to answer some health problems to the community. HC felt that clients paid more respects to their words for some reasons: they were in identical age group, preferred to use common and simple language during the explanation and assisted clients dealing with practical procedural problems such as where to do health check or to manage health insurance.

"I remember when I tried to explain dementia to my clients, he paid so much attention and thought that I might also had similar problem, for our age probably were not far too different.. (giggling).. " (HC 5, female, ED)

"The client also got clear explanation about the result of blood pressure examination. I usually explained the systolic and diastolic term with my own words. They were very happy because they easily understand it" (HC 9, male, ED).

"We had interactive session especially when we did breast self examination. They did not hesitate to ask for the exam just because I am also female. Later I figured out that one of client's relatives had mumps and I helped her to refer to primary health care" (CH 9, female, RAW).

Respect due to Personal Attachment in Discussing Sensitive Health Problem

Some clients suffered from sensitive health problem related to their condition or age such as erectile dysfunction in older men or breast abnormal shape in females. Clients felt more comfortable to tell their problems without any anxieties found, especially when they have already had long term interaction to the HC. Despite HC couldn't give further advices due to their limited knowledge and roles, they could motivate clients to consult practitioners nearby.

"Having got education and breast self examination practices, one client shared her sensitive things and complaints related to her breast lump and anxieties feelings of what to do afterwards " (HC 11, Female, RAW)

"I also encouraged my neighbour to go to the hospital for further breast examination and management from the practicioners as well as described her husband about the condition firstly" (HC 12, female, RAW)

"Having checked one of client's blood pressures, he told me about men's health problem. I think he could tell me his problem because he felt free to discuss it with me and I might have advices on it" (HC 3, female, ED)

Challenge

Within 5-years program, challenges of being HC mostly came at the beginning of the programs as ED and RAW group said. The challenges did not only come from the clients but also from the client's family. Another challenge was when they refused to see the "scary picture" of breast cancer effect.

"At the beginning, people didn't pay attention to me and I was being ignored, especially at the first year of the program. Fortunately, once I showed my skill to do blood pressure examination gradually we had closer attachment and they started to give more attentions to me, trust me and ask questions

related to health problems". (HC 11, female, RAW)

"The challenge sometimes came from the client's family. " I experienced facing an angry husband of my neighbor's when I accompanied her wife to consult the practitioner in hospital. Her husband was angry with me and would blame me if something happened to his wife" (HC12, female, RAW).

"Sometimes it's hard to make other member of the family agree for the recommendation even though the client was already agree to see a doctor for his hypertension management" (HC 10, female, RAW).

"Sometimes it's sad to see my own family did not run healthy lifestyle as I suggested, that they could not quit smoking or did not want to consult practitioners once they had hypertension" (HC1, female, ED).

"Please don't show the picture" as one of my clients said, "because I'm afraid" (HC 13`, female, RAW). "To ask the client with suspected lump in the breast to do further examination and see a practitioner is another challenge" (HC 13, female, RAW)

Role of Supervisor in Dealing with Challenges

Despite trying to face the challenge by themselves, HC also discussed their difficulties with the area supervisor. Moreover, supervisors also had challenges especially related to the ED groups who might have some physical limitations such as memory.

"Usually, when HC had problems and found challenges, they told me in the meeting and we tried to find the solutions together, one of AS stated. (AS 3, female)

"I had to explain slower and step by step to HC in elderly group because sometimes they forgot easily so I had them repeat my explanation to make sure that they understood and remembered (AS 4, female).

"We can not expect them to understand and to remember a lot of information compared to youth HC (AS 5, male).

Future Plan

The researchers investigated what HC were going to do when the program is completely finished, whether they would continue their role as HC and help the primary health care (PHC) to support the health promotion program or not. Most of them were interested to keep their role as HC.

"As long as the people in the community need me, I will help them" (HC 1, female, ED),

"I was also asked by the PHC to help them in filariasis program" (HC 6, female, ED).

"We also just joined TB Program in our area" (HC 12 and 13, female, RAW) said.

"I also became a volunteer in "RW Siaga" thus, I still can contribute to help the community (HC 3, male, ED)."

"I'm also an active HC for mother and child integrated post program. Since the PHC staff knew that I had ability to educate people, they asked me to educate people (HC 16, female, RAW)."

All HC agreed to sustain their roles, to give community education related to healthier life from examining blood pressure to some health problem early detection activity. The similarities and differences associated with HC personal value, their challenges and future plans based on FGD result between two groups is presented in Table 2.

Table 2. Summary of Personal Value, Challenge and Future Plan of the HCs

Personal Values	Elderly (ED)	Reproductive age women (RAW)
Personal Value on Individual Level	Increasing knowledge and skill on early detection	
	Gaining pride and self confidence from social recognition	
	Financial support: incentives are relatively additional, because they had already earned pension income	Financial support: incentives are more expected to support daily family needs
	Benefit for health: peer education and social interaction may maintain their cognitive and social function to prevent dementia	More confidence in public speaking
Personal Value on Family Level	Recognition of role model of healthy life style The secure feeling in the family due to health cadre knowledge Respect due to blood pressure check skills	
Personal Value on Community Level	Respect due to practical knowledge of relevant health problem	
	Respect due to personal attachment in discussing sensitive health problem	
	Kits received by HCs can give benefit for continous health education and early detection activity in the community	
	Recognition from pensioners club	Recognition especially from PHC
Challenges	Client family was object to follow cadre advice	
	Physical and memory limitation	Obstacles in getting people's attention at the beginning of the program
Future Plan if the Program Completed	Some cadres sustain their HC roles in their communities Involvement in PHC Promotive Prevention Program for some HC	

Discussion

This study is a part of monitoring evaluation of Daya Empowerment Program, managed by pensioner bank collaborated with GAF and FMUI and developed in 9 cities out of 3 provinces in Indonesia which are Bogor, Depok, Bekasi, Serang, Pandeglang, Cirebon, Sukabumi, Cianjur, and Probolinggo. This program selected and recruited clients, lay people from elderly (ED) and reproductive age women (RAW) communities since 2012 and trained them to be peer health educator. The concept of peer educator known and widely used in community empowerment program. Students instructed in groups by their peers showed a much higher degree of Breast Self Examination knowledge. It was also found that perceived confidence of the students educated both individually and in groups increased afterward.[4]

For the program, they were trained with the health education materials and the skills of blood pressure examination and education skill. The health education materials were developed by GAF and FMUI in a form of handbook of protocols and flip chart. Previously, HC had attended capacity increment training conducted by FMUI related to hypertension, balance diet, active and healthy lifestyle, breast cancer as written in the handbook of protocols and flip chart, as well as the educational technique of doing blood pressure examination and communication. Having done some structured trainings and passed the selection, 52 cadres were selected and given some helpful tools to support

their activities. Moreover, the knowledge and skills reinforcement were facilitated during the meeting with the supervisor.

The elderly community cadres which were mostly above 55 years old female pensioners, performed at least 5 times monthly activities to elderly communities: measuring requisite blood pressure examination and anthropometry; undertaking more individual counselling rather than group education related to self-care management based on the clients complain with guidance from handbook of protocols. Moreover, they also informed the client to go to the health care facilities when they had alarm sign. To support this, they were well occupied to early detection algorithm, protocol about obesity, hypertension, suspected diabetes mellitus and suspected dementia and giving primary prevention tips accordingly.

The reproductive age women community HC in 5 cities, performed blood pressure examination and provided health education to the reproductive-age bank clients women in the community. The health education topics were recognizing breast cancer, applying healthy and free-obesity life along with healthy-fit body. Moreover, all cadres who were reproductive age females must perform this activity to number RAW groups in their houses 8 times a month at any rate.

There were 9 supervisors supervised and guided the HC activities in each area. The supervisors were local medical doctors who evaluated, maintained and trained cadre's skill in performing monthly meeting health education and blood pressure check and attended annual centralized refreshment training in Jakarta.The cadres earned approximately 40 USD per month to appreciate to their effort. Supervisors and program management team maintained frequent formal and non-formal communication during implementation and conduct training on how the program gave benefit to the community and how happy they are being the health cadres.

The novelty of this study is exploration of personal value of HC who successfully maintained their long term services, 5 years program implementation, in two age groups: elderly and reproductive age women. The data reveals both productive and elderly group could be HC and remain active for long term implementation. This study provided data of underlying personal values that may be useful for program manager to design efficient peer health educator program.

We inform the cadres personal values which include individual, family and community level adapted from conceptual framework developed by Alam et al.[4] Based on FGD result, we tried to investigate the similarities and differences benefits and the challenges of each personal value level between two groups, elderly and reproductive age.

The first similarity between two groups at individual level is the knowledge and skills enhancement on early detection. Additional health knowledge and skills helped HC to face potential individual or family health problem. These finding was supported by Greenspan studies which stated that community health workers were interested in learning health tips to 'save' themselves and their families. Taylor et all also showed same results in wihich HC in their program stated that gain knowledge is more benefit to me.[6] Furthermore, some cadres viewed knowledge they gained as a form of payment.[2,3] This benefit was more obvious in elderly cadres because they are more prone to the degenerative disease taught e.g. hypertension.

Another similarity between two groups at individual level is gaining pride and self confidence from social recognition. Most HC felt more confidence, got pride and more meaningful life. The perception of usefulness were prominent in their confession, due to the chance they had to help their peer. These statements are similar to a study in Ghana who stated that many respondents were extremely proud to be the community-based surveillance volunteer (CBSV) due to gained respect and recognition from their communities, elders, and the health system from their roles.[5] Greenspan et al[3] so emphasized recognition and encouragement benefit as 'you get fame' as benefit of being health cadre.[3]

Despite the similarities, we also found some differences between these two groups. In elderly groups, peer education and social interaction may maintain HC cognitive and social function to prevent dementia. Retaining educational material trained their brain memory function. The worth feeling and social interaction were also stated as decent benefit elderly cadres gained from the activity. It is very common for the elderly to have less activities and social interactions during retirement period. For being a HC provided them a number of opportunities to meet other people and to have social interaction, as cohort study done in Connecticut found that elderly people who had no social ties were at increased risk about 2 times for incident cognitive decline.[8] In addition, Fratiglioni et al[9] on the systematic review stated that an active and socially integrated lifestyle in

late life protects against dementia and alzheimer disease. Repetition of giving education tips helped them maintain their cognitive function. Meanwhile, compared to elderly group, RAW group showed more confidence in public speaking as the RAW group gave more peer group education while elderly cadres gave education as a personal counselling. However, this data did not contribute to alter their worth perception.

We also found incentive benefit differences they got from this program. Most HC from ED group stated that incentives are additional. Meanwhile, HC from RAW group said that incentives are more expected to support family needs. This different perception resulted from different HC backgrounds. As pensioners, ED group earned another income from their retirement fund. Conversely, HC from RAW group are ordinary housewives. The HC incentive benefit got in RAW group is similar to HC statement in Tanzania that they received some financial and material supports from community members in the form of food, help with farm work, and payment for services received and used to fulfill basic needs.[3]

From financial perspectives, even though some HC might be unpaid, or might receive small monthly stipend, regular and stable recompense, precisely, gave more benefit to them. The $40 stipend earned from this program did not seem to affect their altruistic drive. Their activity was so mobile and obliged them to visit clients' house in significant distance (around 2 km away), therefore, it was only considered as transportation wage.[5] Bhattachariyya et al examined experience with various incentives for CHWs and their impact on retention of CHWs and the sustainability of CHW programs. It reviews the types of incentives that are needed to motivate involvement, to retain CHWs once they have been trained, and to sustain their performance at acceptable levels especially in nutrition community-based program.[1] Monetary incentives can increase retention. CHWs are poor people trying to support their families, but monetary incentives often bring a host of problems because the money may not be enough, may not be paid regularly, or may stop altogether. Monetary incentives may also cause problems among different cadres of development workers who are paid and not paid. However, there are some success stories of programs paying CHWs. Many programs have used in-kind incentives effectively.[1] In our study, most of the HCs said that monetary incentives are benefit but those were not their main personal benefit ot this program. Still the social recognition from the community mostly was their main personal value joining this program. It was coherent with study done by Reis et al[10] about HC in Posyandu that more important thing was appreciation of their activity from the community.

On family level, the similarities found between these two groups are recognition of healthy life style role model and the secure feeling in the family due to health cadre knowledge. As CHW, one of the cadres said that she loved the work and even though she was not paid, her family members told her: work hard, keep volunteering because one day you can be successful, you can go and get more knowledge and bring it home for us and we can see how to copy it.[3]

Meanwhile, the similarities found in ED and RAW groups personal value on community level are when the community respect HC due to their relevant and practical health problem knowledge they shared like blood pressure check skills.

The feelings of being valuable HC in their neighborhood is in line with Tanzania HC who wished to improve the status quo in their communities through health education and desired to educate community: I saw it was an opportunity to get in and to help my community.[3] This was also stated by CHWs in Ghana that altruism towards the community emerged as a key reason for becoming volunteers and as a motivation to stay in the role.[7]

The Tanzania HC were also provided with education and early detection kits such as flip charts, handbook protocol, sphygmomanometer and stethoscope. Hopefully by having the kits, the community could also have advantages to increase their health knowledge such as their blood pressure. The same condition found in Tanzania, CHW's tools such as bicycles, weighing scales, register books, job aids can give hope.

On community level which is not stated clearly in Greenspan[3] and Dil[5] studies but found in ED and RAW HC groups, the community respect was achieved through personal attachment in discussing sensitive health problems and the unique roles as a peer-group educator through some materials like breast cancer.

The difference personal value between two groups on community level is whom they got recognition from. As pensioners, HC in ED group got more recognition from their pensioner club. Meanwhile, HC in RAW group got more recognition from PHC staff since they usually were asked to join health promotion program in their community. This recognition is in line with the CHWs in Ghana and

Tanzania who gained respect and recognition from their communities, elders, and the health system.[3,5]

Almost all the HC faced the challenges during their activity. When HC in ED and RAW group have the client's family as the object to understand and follow their advices, however, sometimes, the challenge came from the family members who acted differently.[11] Another challenge found was when HC in ED groups faced physical and memory limitation to conduct the program. Meanwhile, HC in RAW groups found difficulties to get client's attention at the beginning of the program. However, HC in RAW groups tried to find the solutions with the assistance of their area supervisors by doing monthly meeting discussion to refresh their knowledge and skills. The supervisors also asked them to demonstrate how to give education and get feedback afterwards. Conversely, the elderly HC, needs extra-times to understand the explanation and to apply their skills repeatedly and slowly. Moreover, while doing discussion, the area supervisor also designed the schedule in relevance to the elderly physical condition.

The challenges mentioned previoulsy in this program are quite different from those in Ghana and Tanzania. Most Ghana and Tanzania cadres got late and less incentives, less equipment and kept up with their farming schedule due to fulfilment of their financial needs.[3,5] Both HC in ED and RAW group have similar future plans on what to do after this program finished. Some cadres keep taking role as HC and get involve in PHC Promotive Prevention Program in their communities. Some of the HC are well-known by the PHC and often were asked to help the program such as participated in integrated post for mother and child's health. It's also the same condition in Tanzania, despite the challenges, the CHWs said that they continued their volunteer work, often for over a decade, with neither an abundance of financial resources of their own nor substantial financial or material remuneration. Despite studies revealed that incentives were major factor that motivated cadres, we use model from studies that categorizing personal values into individual, family, community and organizational level.[3]

Conclusion

Elderly community are still resourceful to be empowered as peer health educator, because their motivation is not only to have social recognition, financial support or additional health knowledge. Beyond that, they require the activity and recognition as one way to retain their cognitive and social function. They might be more effective in gaining trust to handle peer health education especially dealing with sensitive health issues in elderly. Reproductive age women were similarly resourceful to deal with relevant sensitive issues in health education like self-breast examination. Therefore, prominent challenges in gaining trust when starting peer health educator can be minimized by employing age-appropriate cadre to deal sensitive health issues. Another way to improve better rapport for peer was strived by conducting blood measure check or practicing self breast examination movement together in the group.

Combination of respect, recognition from family and community, financial support, perception of usefulness, additional practical health knowledge and early detection skill and better perceived health status especially cognitive in elderly, had motivated health cadre to maintain their dedication and services in 5 years peer health educator program. Those perceived personal values might be an important lesson for public health practitioner in designing long term public health intervention program.

Acknowledgement

The authors would like to thank you for the four years of awesome, strong collaboration, support and partnership to BTPN, GAF. The Authors also would like to thank you for all the HC and supervisors involved in this program, especially for their active participation in empowering the community.

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