



# HIFA discussion on CHW: Empowering CHWs to accelerate progress towards Universal Health Coverage

Complete Compilation

## CHW (1) Welcome to the WHO-HSG-HIFA discussion on Community Health Workers!

31 May, 2019

Dear HIFA colleagues,

Welcome to the WHO-HSG-HIFA discussion on Community Health Workers! Special welcome to all those who have joined us in the past few days. Our purpose is to share views, experience and expertise on \*how\* more effectively to support CHWs to accelerate progress towards universal health coverage.

As a personal comment, I have been encouraged and excited over the past 5-10 years by the growing 'global health movement' in support of CHWs. Research has clearly demonstrated that lay health workers - if well trained and supervised - can safely provide a wide range of primary health services. CHWs are recognised as having a huge potential to help accelerate progress towards universal health coverage and other SDG health targets. At the same time, these high expectations are daunting. The potential of CHWs will not be realised unless they are adequately supported to provide the care for which they are trained. To do this effectively will require a huge coordinated effort at all levels of the health system

Our role here on the HIFA forums is to freely share our views, experience and expertise around CHWs. We are especially keen to hear from those who are working on the front line: CHWs and the people who work with them. We are equally keen to hear from researchers, policymakers, publishers, social scientists and indeed all disciplines represented on HIFA. The challenge of 'how more effectively to support CHWs' requires a multidisciplinary approach.

We shall be guided in our discussions by the recently launched WHO Guideline on health policy and system support to optimize community health worker programmes (CHW Guideline). This provides a number of recommendations for consideration by national ministries of health and the wider global health community. To get the most out of the upcoming discussion I encourage you to review the recommendations of the CHW Guideline. You can download selected highlights here in all six UN official languages: <https://www.who.int/hrh/community/en/>

Our first thematic discussion starts officially tomorrow 1 June 2019 and will continue for 6 weeks. I shall post shortly in a separate message some questions that we have developed to help frame the discussion.

In the meantime, please continue to spread the word and invite more people to join us!

<http://www.hifa.org/news/who-hsg-hifa-collaboration-empowering-community...>

Our thanks to the members of the HIFA working group on CHWs who have given their time and expertise voluntarily to serve this project. And to WHO for their support.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (2) Overview of CHW programmes in Afghanistan, Egypt and Pakistan

31 May, 2019

Dear HIFA colleagues,

Over the coming days, weeks and months we encourage you to share news and publications relating to CHWs, as part of our commitment to WHO for our CHW project. Below are the citation and abstract of a paper that was shared yesterday by author Moazzam Ali on the IBP forum.

I suspect this paper was published after the evidence synthesis work of the CHW Guideline development group. This raises the question: How best to integrate emerging new evidence into the growing global knowledge base on CHWs, in a way that is most useful for consideration/application in policy and practice? The current Guideline notes (p66): 'Recognizing the potential for additional research to modify and strengthen the evidence base that informed the development of this guideline, the need and opportunity for a potential update will be considered five years after publication.'

CITATION: Citation: Folz R; Ali M. Overview of community health worker programmes in Afghanistan, Egypt and Pakistan. East Mediterr Health J. 2018;24(9):940-950 <https://doi.org/10.26719/2018.24.9.940>

Correspondence to: M. Ali: [alimoa@who.int](mailto:alimoa@who.int)

#### ABSTRACT

**Background:** Community health workers (CHWs) help reduce healthcare disparities and improve access to and quality of care in many countries.

**Aim:** To provide an overview to compare and contrast characteristics of CHW programmes in Egypt, Pakistan and Afghanistan and describe the strengths, weaknesses and challenges of the programmes.

**Methods:** Scientific databases and grey literature were searched including PubMed, Medline, Cochrane Review Library, WHO databases, and grey literature websites including those of national health ministries. We shortlisted 23 articles to be included in this study.

**Results:** The three programmes reviewed vary in their organization, structure, enrolment and payment structure for CHWs. Key challenges identified in the review include: commodity security that compromises quality of services; inadequate and irregular training; unpredictable or inadequate remuneration structure; and lack of standardization among organizations and government ministries. Strengths identified are that the programmes are accepted and integrated into many communities; and have the support of health ministries, which enhances sustainability and regulates standardized training and supervision. These also increase participation and empowerment of women, evident in the fact that CHWs have organized

among themselves to demand better treatment and more respect for the work that they do.

Conclusion: Our findings should alert policy-makers to the need to review CHWs' scope of practice, update education curricula, and prioritize in-service training modules and improved working conditions. The effectiveness and impact of CHW programmes has been shown countless times, demonstrating that task sharing in healthcare is a successful strategy with which to approach global health goals.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (3) What are your thoughts on the Guideline?

### What questions do you have about it?

31 May, 2019

Dear HIFA colleagues,

Here are the four suggested questions to guide us through our first thematic discussion, starting tomorrow 1 June 2019. This first discussion will focus on selection, pre-service training, and certification issues (Guideline Recommendations 1,2,3,4,5). However, we welcome contributions on *any* aspect of CHWs at *any* time. And, to start us off, we especially welcome your inputs on Question 1: What are your thoughts on the Guideline? What questions do you have about it?

Q1. What are your thoughts on the Guideline? What questions do you have about it?

Q2. Recommendation 1 suggests certain criteria to use and not to use for selection of CHWs. How do these criteria relate to current practice in your country/experience? Are these criteria implementable in your country/experience?

Q3. Recommendations 2, 3 and 4 make suggestions on length of pre-service training, competency domains and modalities. How do these suggestions relate to current practice in your country/experience? Are they implementable in your country/experience?

Q4. Recommendation 5 suggests using competency-based formal certification for CHWs who have successfully completed pre-service training. How does this suggestion relate to current practice in your country/experience? Is it implementable in your country/experience?

The new WHO Guideline: Health policy and system support to optimize community based health worker programmes is available here:

<https://www.who.int/hrh/community/en/>

From this URL you can download the Guideline in full (116 pages). Selected highlights (12 pages) are available in Arabic, English, French, Portuguese, Russian and Spanish.

We look forward to learn from your experience and expertise. We especially welcome input from the front line of primary health care, from CHWs and those who work with them. That said, \*everyone\* on HIFA potentially has something to contribute. To send a message to HIFA, simply send an email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

(If any questions, email me at [neil@hifa.org](mailto:neil@hifa.org) )

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (4) Leveraging social media in support of CHWs

31 May, 2019

Neil, thank you for your leadership in coordinating the upcoming CHW discussion. We are trying to leverage social media in new and exciting ways over the next 18 months. Thanks to the entire HIFA Social Media Working Group for your ideas and encouragement!

The more engagement we have with this discussion on other platforms, such as Twitter, Instagram, and Facebook, the more perspectives we can learn from, and the more people we can bring into HIFA.

I am grateful for all of your help in making this hopefully an exciting and productive discussion.

Amelia Plant, MPH  
Maternal & Child Health, UC Berkeley

LinkedIn: <https://www.linkedin.com/in/ameliant/>

HIFA profile: Amelia Plant is a consultant in sexual & reproductive health research & practice. Projects have included: managing grants to African-based organizations that distribute contraceptives at the community level; surveying the data that links contraceptive use and fertility decline with economic development; co-authoring an online abortion course; and coding and analyzing qualitative data about LGBTQ experiences. Amelia is a member of both the HIFA project on community-health workers and the HIFA project on family planning. She is originally from the USA and is currently based in Tunis, Tunisia. She is a member of the HIFA working group on Family Planning

<http://www.hifa.org/support/members/amelia>

<http://www.hifa.org/projects/family-planning>

asiplant AT gmail.com

## CHWs (5) Leveraging social media in support of CHWs

(2)

31 May, 2019

Thanks Amelia,

"Thanks to the entire HIFA Social Media Working Group for your ideas and encouragement!"

Yes indeed. Thanks to Jules Storr (Consultant, WHO and Coordinator of the HIFA Social Media Working Group) and the team for your support.

"The more engagement we have with this discussion on other platforms, such as Twitter, Instagram, and Facebook, the more perspectives we can learn from, and the more people we can bring into HIFA."

Absolutely. Please all use your social networks to let people know about this dialogue and invite them to join: [www.hifa.org/joinhifa](http://www.hifa.org/joinhifa) Please also feel free to tweet or post questions to your networks and let us know what they have to say.

Another social media is WhatsApp, and what is especially exciting about WhatsApp is that it is commonly used by CHWs around the world. It would be wonderful if we can get some input via WhatsApp. Is anyone on HIFA already a member of a WhatsApp group that includes CHWs? If so, please get in touch and we can discuss how to engage: [neil@hifa.org](mailto:neil@hifa.org)

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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## CHWs (6) What are your thoughts on the Guideline? (2)

1 June, 2019

"By fully harnessing the potential of community health workers, including by dramatically improving their working and living conditions, we can make progress together towards universal health coverage and achieving the

health targets of the Sustainable Development Goals.” Dr Tedros Adhanom Ghebreyesus, Director-General, World Health Organization

The new WHO Guideline on Health policy and system support to optimize community health worker programmes provides evidence-informed guidance on \*how\* to fully harness the potential of CHWs.

Download the highlights here:

<https://apps.who.int/iris/bitstream/handle/10665/275501/WHO-HIS-HWF-CHW-...>

Barriers to achieving health goals

- Lack of health workers,
- Unevenly distributed health workers and facilities,
- Most vulnerable people and communities unable to access health services,
- Low quality of care, and
- Inadequate health worker training, supervision and support.

The WHO Global Strategy on Human Resources for Health: Workforce 2030 encourages countries to adopt a diverse, sustainable skills mix, harnessing the potential of community-based and mid-level health workers in inter-professional primary care teams.

The WHO document on which this product is based provides evidence-based policy guidance to support national strategies and investments to build fit-for purpose community-based health workforces.

The increased coverage of essential health services and improved equity in coverage envisioned by well-functioning community health worker programmes will result in fewer deaths and illnesses and lower disease burdens.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (7) Our CHW project is now publicised on the WHO website

1 June, 2019

Dear HIFA colleagues,

Our CHW project is now publicised on the WHO website!

<https://www.who.int/hrh/news/2019/collaborative-discussion-hwf-uhc/en/>

New members are rolling in! Welcome! Thanks everyone for your efforts to raise visibility.

Please continue to spread the word, by email, twitter, facebook... You may like to point people to the URL above as this endorsement by WHO will help encourage more people to join us.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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## CHWs (8) Community health centres and Positive Practice Environments

2 June, 2019

I was interested to see this new report from Jan De Maeseneer and colleagues at the International Centre for Family Medicine and Primary Health Care, published by the International Federation of Community Health Centres (May 2019).

Below are the citation, abstract and table of 'cross-cutting characteristics of community health centres'. I note that the concept of 'community health centres' and their desired characteristics are not mentioned as such in the WHO Guideline on CHWs, and, conversely, that this new report does not acknowledge the WHO Guideline. Is there a disconnect here?

The WHO Guideline includes recommendations that relate indirectly to health centres (eg Recommendation 15: Availability of supplies) but I wonder if more could be done to promote the concept of enabling, Positive Practice Environments? (This concept was championed by the International Council of Nurses several years ago, and HIFA contributed directly with guidance on the availability and use of information at the point of care.)

Full text: <http://www.ifchc.org/wp-content/uploads/2019/05/Community-Health-Centres...>

CITATION: Community Health Centres: Operationalizing the Declaration of Astana on Primary Health Care

Jan De Maeseneer MD PhD<sup>1</sup>; Antonija Poplas Susič MD PhD<sup>2</sup>; Scott A Wolfe MA<sup>3</sup>; Meng Qingyue MD PhD<sup>4</sup>; Shabir Moosa MFamMed MBA PhD<sup>5</sup>; Lynne Raskin RN<sup>6</sup>; Tom Symondson BSc<sup>7</sup>; Daniel R Hawkins BA<sup>8</sup>

Corresponding author: Dr. Jan De Maeseneer ([jan.demaeseneer@ugent.be](mailto:jan.demaeseneer@ugent.be))

**ABSTRACT:** Community Health Centres (CHCs) are community-oriented primary care (COPC) organizations that deliver health and social services through interprofessional teams, addressing the specific health and social needs of individuals, families and local communities. CHCs involve members of the community in planning and programming, and they employ a multi-sector approach to address social determinants of health. CHCs currently exist in dozens of countries around the world but there remains limited comparative information nor policy/planning guidance across jurisdictions for use by stakeholders wishing to implement and support CHCs. Insights from CHCs in numerous countries help increase understanding of the

comprehensive CHC approach and how CHCs provide countries and non-governmental organizations a model to operationalize primary health care as articulated in the Declaration of Astana on Primary Health Care and to achieve sustainable developments goals.

**METHODS:** Incremental purposive sampling based on the domain-experience of the authors, supplemented by descriptive information, and practice- and policy-relevant information.

#### TABLE 1: CROSS-CUTTING CHARACTERISTICS OF COMMUNITY HEALTH CENTRES

- Historical background in societal and health care transitions;
- Focus on accessibility with special attention for vulnerable and marginalized groups;
- Accountability for services to a defined population, usually based on a geographical catchment area;
- A comprehensive person-centered approach, integrating primary care with: chronic care and other forms of frontline care (dental, vision, mental health, etc); health promotion and community participation; and various social services;
- An inter-professional team with available providers including family physicians, nurses, social workers, nutritionists, health promoters, dentists, physiotherapists, community health workers, community pharmacists, and others;
- Focus on upstream causes of ill-health, addressing social and environmental determinants of health, through intersectoral action involving housing, education, migration, and other sectors;
- Demonstrated positive results in terms of quality, outcomes, cost-effectiveness and sustainability;
- Often a front-runner in introduction of innovation and involved as role-model in health professional education with emphasis on collaborative care;
- Contributing to social cohesion and solidarity in communities.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (9) What are your thoughts on the Guideline? (3)

2 June, 2019

Dear HIFA colleagues,

I forward the message below from HIFA-Zambia. Flata Mwale, an MSc Global Health student at the University of Malawi, raises some important issues.

For example: "I personally feel if adopted by nations, the guidelines will serve both the objective of the health systems as well as well as act as a protective and empowerment document to the CHWs who in my opinion have been abused by the system as well as we the health providers. The lack of any document to protect their interests especially those in rural areas where supervision and monitoring of responsible cadres are still inadequate and have placed CHWs literally at the mercy of their immediate supervisors."

The WHO Guideline on CHWs does emphasise (Recommendation 6) \*Supportive\* supervision, and it is hoped this will lead to improvements to what Flata describes. Perhaps the greatest risk of the whole challenge of CHW programming (as with other cadres) is that they are not adequately empowered to deliver the work for which they are trained. Like other health workers, CHWs have a range of basic needs that must be met if they are to deliver their potential in harmony with both the community and the wider health workforce. Read on...

[hifa-zambia] CHWs (3) What are your thoughts on the new CHW Guideline? What questions do you have about it? (2)

I am new to this forum and I'm glad that the first issue am seeing under discussion is the CHW guidelines

[\[https://www.who.int/hrh/community/en/\]](https://www.who.int/hrh/community/en/). Having served in the public service and private as well, the relevance of the guidelines couldn't have come at a better time than now when the world Community is advocating for universal health care and the SDG 3.

I personally feel if adopted by nations, the guidelines will serve both the objective of the health systems as well as well as act as a protective and empowerment document to the CHWs who in my opinion have been abused by the system as well as we the health providers. The lack of any document to protect their interests especially those in rural areas where supervision and monitoring of responsible cadres are still inadequate and have placed CHWs literally at the mercy of their immediate supervisors. The work they are doing in contributing to achieving global public health deserves recognition. Such a document may help also to bring in younger people who can support the sector and again be empowered through skills training and can be helpful in scaling up such as youth friendly health services too. This will also address the inequalities in access and utilization of health care for the underserved as our country continues to struggle in reaching many against an inadequate workforce.

Thank you for such a document to all involved in this and to the global health leader (WHO) for ensuring its successful recognition.

But like any other Evidence based program, implementation in Zambia will require a well thought out multi- sectoral approach just like most developing countries where resources are limited to ensure sustainability. I feel with a great community involvement including business sector and a "Value for evidence" led system the guidelines will address the current human resource gap we are experiencing. The businesses running within these communities can be a great source of support for this program and must be involved from program designing stage.

For the most times that we have ignored the beneficiaries as part of the process of implementation, we have failed to sustain most programs and therefore I strongly feel community involvement through health information on all programs must be key to create a sense of ownership. Giving the community the power to have a say in this whole process will be crucial. Research continues to reveal that community involvement yields great results and Zambia must go this way.

My only question on this now for Hifa-Zambia is where are we in adopting the guidelines?

Best wishes to you all,

Flata Mwale - Medical laboratory Officer/ Student (MSc Global Health Implementation- College of Medicine Malawi)

HIFA-Zambia profile: Flata Mwale is a Student at the College of Medicine, University of Malawi. Professional interests: Health systems strengthening and health policy. Advocacy for equity and equality in access, utilization and distribution of health care. Email address: fltmwale AT gmail.com

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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Join CHIFA: <http://www.hifa.org/join/join-chifa-child-health-and-rights>

Join HIFA-Portuguese: <http://www.hifa.org/join/junte-se-ao-hifa-portuguese>

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Join HIFA-Zambia: <http://www.hifa.org/join/join-hifa-zambia>

CHWs (10) Does volunteer community health work empower women? Evidence from Ethiopia's Women's Development Army

2 June, 2019

Dear HIFA colleagues,

Below are the citation, abstract, key messages and selected extracts of a new paper in Health Policy and Planning.

CITATION: Does volunteer community health work empower women?  
Evidence from Ethiopia's Women's Development Army

Svea Closser Harriet Napier Kenneth Maes Roza Abesha Hana Gebremariam  
Grace Backe Sarah Fossett Yihenew Tesfaye

Health Policy and Planning,  
czz025, <https://doi.org/10.1093/heapol/czz025>

Published: 29 May 2019 [restricted-access]

## ABSTRACT

Of the millions of Community Health Workers (CHWs) serving their communities across the world, there are approximately twice as many female CHWs as there are male. Hiring women has in many cases become an ethical expectation, in part because working as a CHW is often seen as empowering the CHW herself to enact positive change in her community. This article draws on interviews, participant observation, document review and a survey carried out in rural Amhara, Ethiopia from 2013 to 2016 to explore discourses and experiences of empowerment among unpaid female CHWs in Ethiopia's Women's Development Army (WDA). This programme was designed to encourage women to leave the house and gain decision-making power vis-à-vis their husbands—and to use this power to achieve specific, state-mandated, domestically centred goals. Some women discovered new opportunities for mobility and self-actualization through this work, and some made positive contributions to the health system. At the same time, by design, women in the WDA had limited ability to exercise political power or gain authority within the structures that employed them, and they were taken away from tending to their individual work demands without compensation. The official rhetoric of the WDA—that women's empowerment can happen by rearranging village-level social relations, without offering poor women opportunities like paid employment, job advancement or the ability to shape government policy—allowed the Ethiopian government and its donors to pursue 'empowerment' without investments in pay for lower-level health workers, or fundamental freedoms introduced into state-society relations

## KEY MESSAGES

1. The Women's Development Army (WDA) offered women new roles, and in a few cases new opportunities.
2. Work for the WDA also reinforced gender hierarchies in new ways, requiring women to work without compensation on pre-determined tasks

directed by top-down government structures.

3. Rhetoric about the empowering aspects of Community Health Worker programmes should not be taken at face value; ethnographic work should be more widely used to reveal the full complexity of programme impacts on women's lives.

#### SELECTED EXTRACTS

The lofty vision of CHWs as intrinsically motivated, empowered community activists often masks a starker reality. Scholars have argued that volunteering in sub-Saharan Africa is a neoliberal practice in that shifts responsibility for key state tasks onto individuals (Swidler and Watkins, 2009; Prince and Brown, 2016). CHWs are frequently disempowered staff at the bottom of health bureaucracies, facing severe restrictions on their ability to advocate for themselves or for the needs of their communities (Walt and Gilson, 1990; Campbell and Scott, 2011; Colvin and Swartz, 2015; Maes, 2015). Unpaid work for health programmes in low-income contexts is often taken up by people who greatly need paid work but who cannot obtain it, and who hope that volunteering will eventually lead to a paid position

Some CHWs may in fact experience forms of disempowerment through their work, if they are treated as disposable labour to be disciplined, rather than as agents who engage in processes of problem identification, policy solutions and political advocacy (Justice, 1984; Morgan, 1993; Nichter, 1996). This dynamic has animated passionate debates (Schaaf et al., 2018). As [HIFA member] David Werner put it in 1981, are CHWs lackeys or liberators?

If programmes fail to provide decent pay, real voice for CHWs in policy decisions, and the advancement of fundamental freedoms, policymakers and donors should be honest that their programmes might not be empowering.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (11) What are your thoughts on the Guideline?

(4)

3 June, 2019

We look forward to your comments on the Guideline. We are especially keen to hear from those working on the front line: CHWs and the people who work with them, as well as CHW programme managers and policymakers. We would also really like to hear from those who were involved in developing the Guideline. Those of us who are not 'CHW specialists' also have an important role in this discussion, not least by asking questions. (I am reminded of my late friend and mentor Andrew Chetley, director of Healthlink Worldwide, whether he had any advice for me. His brief but wise reply: Ask more questions.)

The Guideline is available in several languages here: <https://www.who.int/hrh/community/en/>

To get a quick overview, I recommend the highlights which can be downloaded here:

<https://apps.who.int/iris/bitstream/handle/10665/275501/WHO-HIS-HWF-CHW-...>

On page 4 of the highlights, we read:

Why WHO developed this guideline

Despite the wide recognition and the substantial evidence of their positive potential, the support for CHWs and their integration into health systems and communities are uneven across and within countries. Good-practice examples are not necessarily replicated, and policy options for which there is greater evidence of effectiveness are not adopted uniformly. Conversely, successful delivery of services through CHWs requires evidence-based models for education, deployment and management of these health workers.

This guideline aims to assist national governments and national and international partners to improve the design, implementation, performance and evaluation of CHW programmes, contributing to the progressive realization of universal health coverage.

This guideline is focused primarily on CHWs (as defined by the International Labour Organization through its International Standard Classification of Occupations), but its relevance and applicability also include other types of community-based health workers. The recommendations of this guideline are of relevance to health systems of countries at all levels of socioeconomic development.

The above text raises several issues. For example:

1. Wide recognition of CHWs' potential (as Dr Tedros says in the Foreword to the full Guideline: 'We now have compelling evidence demonstrating the valuable contribution of community health workers in delivering basic and essential life-saving health services.'
2. Integration of CHWs into health systems and communities (this is a paradigm shift for which there is growing consensus but also major challenges; Dr Tedros again: [CHWs are] often operating at the margins of health systems, without being duly recognized, integrated, supported and rewarded for the crucial role they play.)
3. 'Good-practice examples are not necessarily replicated, and policy options for which there is greater evidence of effectiveness are not adopted uniformly' (although, importantly, the Full version of the Guideline notes: 'This guideline is not a blueprint that can be immediately adopted. It should be read as an analytical overview of available evidence that informs a menu of interrelated policy options and recommendations. The options and recommendations subsequently need to be adapted and contextualized to the reality of a specific health system.'

I look forward to your comments on the above.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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CHWs (12) What are your thoughts on the Guideline?

(5) Role of CHWs in disability and rehabilitation

3 June, 2019

A very important discussion about CHWs.

I have 2 questions:

1. Will we include in this discussion also the fact that the Disability & Rehabilitation unit of WHO is thinking about expanding the role of CHWs to the field of rehabilitation in the context of the Rehab 203 Action Plan ensuring that rehabilitation becomes integral part of universal health care?

2. Will we focus also in this discussion on the rehabilitation field worker sometimes called the community (based) rehabilitation worker (CRW) or the community rehabilitation facilitator (CRF): the latter usually being a more mid-level rehabilitation worker?

Thanks for raising this important subject! During the period 1984-1994 when I working in South Africa this was an important topic; still it is!

With kind regards

Huib Cornielje

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If the rich live more simply the poor simply can live (Dom Helder Camara)

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## CHWs (13) Event today: Women Deliver - The Role of CHWs in Delivering RMNCH

3 June, 2019

The message below is forwarded from the CORE Group discussion forum. If any HIFA members are attending this event today, please invite all participants to continue the discussion here on HIFA. And please do send us a note with observations for those of us who are unable to be at Women Deliver in person.

Dear CORE Group,

I wanted to share a poster for an event on empowering community health workers to achieve RMNCH outcomes at Women Deliver that was only recently added to the schedule.

Optimizing Performance Without Power: The Role of CHWs in Delivering RMNCH, June 3rd 3 -5 pm, Room 306

Hosted by: The Bill & Melinda Gates Foundation and OPM, India

Female community health workers form the most important foundation of health systems. We rely deeply on them to deliver on reproductive maternal health outcomes. Yet there is limited attention to their power and status in communities where they work; their own sense of empowerment is linked with their intrinsic motivation as workers and as women in gendered settings of the family, community and health systems. Extrinsically they are not valued by salaries commensurate with their time investments to their community outreach work. We have evidence from across global settings we want to bring to this panel and in collaboration with other agencies that are also working on the same issues. Our evidence will speak to the following questions: What does it take to build a stronger more empowered community health work force and how can this be enabling to achieve better continuum of care for women for RMNCH?

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Best wishes, Neil

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## CHWs (14) What are your thoughts on the Guideline?

(6)

3 June, 2019

Thanks to Neil for sharing our HIFA-Zambia colleague Flata's perspective on the CHW guideline [<http://www.hifa.org/dgroups-rss/chws-9-what-are-your-thoughts-guideline-3>]. The overall goal of the guideline "is to assist national governments and national and international partners to improve the design, implementation, performance and evaluation of CHW programmes, contributing to the progressive realization of universal health coverage."

Although it is not explicitly stated, one would hope that these improvements would also result in more equitable treatment of CHWs, ensuring that they are brought into the conversation as legitimate members of the health work force. I am glad we are starting with the topic of selection, pre-service training, and certification issues. No health system flourishes with large amounts of turnover. These initial processes create agreed-upon expectations and set the stage for effective and fair use of CHWs.

I have two comments about the overall guideline:

1. As we go through each recommendation and discussion, we should keep in mind the questions that the guideline addressed, and the ones it omitted. There are opportunities for future research and some nuanced understanding that may not have been settled by the guideline. Where should we go from here in our research?

2. How can the guideline be best used? Working for a grant maker, I am removed from day-to-day implementation. However, I have observed that any given country has national health plans and a governmental health system that may include CHWs, in addition to multiple other actors working with CHWs. Are these actions coordinated? Should they be? I would love to hear examples from those of you on the ground about how you are using the guideline, or hope to use it, to bring various employers of CHWs together to make the terminology (and the work) more standardized.

Looking forward to further discussion,

Amelia

Amelia Plant, MPH  
Maternal & Child Health, UC Berkeley

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HIFA profile: Amelia Plant is a consultant in sexual & reproductive health research & practice. Projects have included: managing grants to African-based organizations that distribute contraceptives at the community level; surveying the data that links contraceptive use and fertility decline with economic development; co-authoring an online abortion course; and coding and analyzing qualitative data about LGBTQ experiences. Amelia is a member of both the HIFA project on community-health workers and the HIFA project on family planning. She is originally from the USA and is currently based in Cairo. She is a member of the HIFA working group on Family Planning and the HIFA wg on Community Health Workers.

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## CHWs (15) What are your thoughts on the Guideline?

### (7) 15 policy questions

3 June, 2019

Dear Amelia, (we invite input from HIFA members who have been involved in the development of the WHO Guideline - please see below)

You make an important point: "As we go through each recommendation and discussion, we should keep in mind the questions that the guideline addressed, and the ones it omitted. There are opportunities for future research and some nuanced understanding that may not have been settled by the guideline. Where should we go from here in our research?"

The WHO Guideline (fulltext version) provides some background on this (page 24), as follows:

The guideline follows a health system approach. Specifically, it identifies the policy and system enablers required to optimize design and performance of CHW initiatives; within this overall structure, a gender and decent work lens was adopted, in particular in relation to recommendations where those aspects were most relevant. The 15 policy questions that guided the research and informed the recommendations can be structured into three broad categories:

#### SELECTION, EDUCATION AND CERTIFICATION

1. For CHWs being selected for pre-service training, what strategies for selection of applications for CHWs should be adopted over what other strategies?
2. For CHWs receiving pre-service training, should the duration of training be shorter versus longer?
3. For CHWs receiving pre-service training, should the curriculum address specific versus non-specific competencies?
4. For CHWs receiving pre-service training, should the curriculum use specific delivery modalities versus not?
5. For CHWs who have received pre-service training, should competency-based formal certification be used versus not used?

#### MANAGEMENT AND SUPERVISION

6. In the context of CHW programmes, what strategies of supportive

supervision should be adopted over what other strategies?

7. In the context of CHW programmes, should practising CHWs be paid for their work versus not?

8. In the context of CHW programmes, should practising CHWs have a formal contract versus not?

9. In the context of CHW programmes, should practising CHWs have a career ladder opportunity or framework versus not?

## INTEGRATION INTO AND SUPPORT BY HEALTH SYSTEM AND COMMUNITIES

10. In the context of CHW programmes, should there be a target population size versus not?

11. In the context of CHW programmes, should practising CHWs collect, collate, and use health data versus not?

12. In the context of CHW programmes, should practising CHWs work in a multi-cadre team versus in a single-cadre CHW system?

13. In the context of CHW programmes, are community engagement strategies effective in improving CHW programme performance and utilization?

14. In the context of CHW programmes, should practising CHWs mobilize wider community resources for health versus not?

15. In the context of practising CHW programmes, what strategies should be used for ensuring adequate availability of commodities and consumable supplies over what other strategies?

These questions have not been addressed through previous WHO guidelines and represent the core focus of this guideline.

This guideline did not appraise critically the body of evidence on which specific health services CHWs can deliver to

quality standards, and thus it contains no recommendations regarding these aspects. Published evidence and existing WHO guidelines encourage the delegation of certain tasks relating to prevention, diagnosis, treatment and care, for example for HIV, tuberculosis (TB), malaria, other communicable and noncommunicable diseases, a range of reproductive, maternal, newborn and child health services, hygiene and sanitation, ensuring clients'

adherence to treatment, rehabilitation and services for people affected by disabilities, and advocating and facilitating underserved groups' access to services (Figure 2 and Annex 2). Current (and future) disease-specific WHO guidelines remain the primary source of normative guidance on which specific preventive, promotive, diagnostic, curative and care services CHWs are effective in providing (Annex 3).

In addition to the delivery of interventions at the individual and family levels, there is long-standing recognition of the potential for CHWs to play a social and political role at the community level, related to the action on social determinants of health for the transformation of living conditions and community organization. This dimension includes participatory identification with the community of health problems and a reorientation of the concept and the model of health care (26, 27).

It would be really excellent to hear more from HIFA members who were involved in the development of the guideline and, specifically, in the identification and selection of the 15 research questions.

(One might note that all WHO guidelines are developed in a hugely more rigorous and systematic manner than they were less than 20 years ago. Prior to that, they were based largely on expert opinion. Since 2003 WHO guidelines emphasize systematic reviews of evidence.)

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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CHWs (16) What are your thoughts on the Guideline?

(8) Role of CHWs in disability and rehabilitation (2)

4 June, 2019

Thanks for this update.

I wholeheartedly second this suggestion of including CHWs or CBR workers as they are known in many developing countries that prioritised CBR as a strategy for rehabilitation in primary care setting.

This is not a recent development; it was endorsed by WHO as the optimal strategy to reach out to a tenth of the world population, on the heels of the Alma Ata Declaration (Health for All). However, Health ministries in most countries did not adequately address this need owing to the subject being seen as falling under the purview of the departments of Social welfare or Social justice. This, despite the definition of Health getting widened to include prevention and rehabilitation, remained a much neglected area of health. Education of children with disabilities and employment got a boost with UNICEF and ILO supporting work in a CBR matrix but there was no commensurate Development in Health.

The renewed interest by WHO to bring Disability into focus is welcome and timely because CBR today has evolved into Community based Inclusive Development (CBID), thanks to the UNCRPD and the disability movement world wide. We need to now see it as an essential aspect of both primary care and secondary care with countries working towards Universal Health Coverage in the spirit of SDGs.

Leave no one behind !

Best regards,

Sunanda K.Reddy

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

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CHWs (17) What are your thoughts on the Guideline?

(9) Role of CHWs in disability and rehabilitation (3)

4 June, 2019

Dear Sunanda,

You note that CHWs' role in community-based rehabilitation has been endorsed by WHO 'as the optimal strategy to reach out to a tenth of the world population'. Indeed CBR is prominently recognised and promoted by WHO: <https://www.who.int/disabilities/cbr/en/>

A systematic review by the Campbell Collaboration (2015) concluded there is 'Moderate to high quality evidence shows that community-based rehabilitation has a positive impact on people with disabilities'.

<https://campbellcollaboration.org/library/community-based-rehabilitation...>

Page 25 of the full WHO Guideline on CHWs contains a graphic of 'Primary health care services for which there is some evidence of CHW effectiveness', but this does not include disability or rehabilitation.

However, page 24 of the Guideline notes: 'This guideline did not appraise critically the body of evidence on which specific health services CHWs can deliver to quality standards, and thus it contains no recommendations regarding these aspects. Published evidence and existing WHO guidelines encourage the delegation of certain tasks relating to prevention, diagnosis, treatment and care, for example for HIV, tuberculosis (TB), malaria, other communicable and noncommunicable diseases, a range of reproductive, maternal, newborn and child health services, hygiene and sanitation, ensuring clients' adherence to treatment, \*rehabilitation and services for people affected by disabilities\* [my emphasis], and advocating and facilitating underserved groups' access to services.'

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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## ReCHWs (18) Community health centres and Positive Practice Environments (2)

4 June, 2019

Hi Neil,

Thank you for sharing this report on community health centres. It is interesting to note how community health workers are included as part of the interdisciplinary teams in the seven contexts studied within the report. With regard to whether the Guideline should mention community health centres, though, I think we should note that the CHW Guideline is normative guidance on health workers, rather than on community health writ large. There are complementary elements within the Guideline that recommend that CHWs be integrated with health systems and as part of interdisciplinary teams, and certainly the Guideline could support design of the CHW-related parts of centres. In such a brief report, I didn't find it too surprising that the Guideline was not called out specifically, though, as the study looks at a broader issue and a certain subset of contexts.

For countries, the report could be useful in envisioning potential permutations of community health, as health needs and health worker teams evolve.

Thank you for sharing,

Catherine

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HIFA profile: Catherine Kane is a member of the WHO Health Workforce team, responsible for advocacy and dissemination of the Guideline on health policy and system support to optimize community health worker programmes. She has experience with community health worker programmes at strategic and operational levels through WHO, the International Federation of Red Cross and Red Crescent Societies and at one point as a social worker supporting migrant communities. Twitter: readycat

## CHWs (19) What are your thoughts on the Guideline? (10)

4 June, 2019

Dear HIFA members,

Thank you for your contributions to the discussion so far! Please keep them coming. To contribute, just reply or send an email to [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

Any questions or comments, ask me: [neil@hifa.org](mailto:neil@hifa.org)

To recap:

This week we are looking at the WHO guideline in general. What are your thoughts on it? What questions do you have?

In the coming weeks we'll look at the first 5 recommendations of the Guideline, on selection, pre-service training and certification.

Throughout, we welcome contributions on any aspect of CHW programming.

You can review selected highlights of the Guideline here:

<https://apps.who.int/iris/bitstream/handle/10665/275501/WHO-HIS-HWF-CHW-...>

For background information and the full version of the Guideline (in several languages) see: <https://www.who.int/hrh/community/en/>

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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CHWs (20) What are your thoughts on the Guideline?  
(11) Role of CHWs in disability and rehabilitation (4)

5 June, 2019

Dear Neil,

Thank you for pointing this out from the guideline. CBR/CBID programs [\*see note below] are growing increasing importance across LMICs with CHWs at the heart of this community based approach.

They are not only helping in crucial aspects of providing rehabilitation but also in identification, screening and prevention of further disabilities among individuals. From my observation, I have seen numerous cases wherein PwDs [\*]refused to go to the nearest hospital/ CHC primarily due to stigmatisation and lack of awareness regarding what needs to be done or were reluctant as they thought seeking medical help would require spending a lot.

Under these circumstances, CHWs play an imperative role in making people aware about health, the importance of not neglecting it, especially when there are chances of it leading to a disability and also about various healthcare schemes, subsidies etc. They also play a critical role in identifying, creating awareness and reducing neglect associated with cases of mental health.

More number of tertiary hospitals must be encouraged to establish CBR and CBR+ programs and be responsible for the training of efficient health aids in

order to reduce the burden of NCDs and communicable diseases within the community.

Thanks,

Stuti

HIFA profile: Stuti Chakraborty is an undergraduate student from Christian Medical College, Vellore. Areas of interest: 1) Disability prevention and awareness; 2) Community based rehabilitation; 3) Research on NCDs; 4) Neurosciences (Brain Injury and CVA) ; 5) Sexual and Reproductive Health Rights of Women with disabilities; 6) Gender inequality and disability. [stutibb@gmail.com](mailto:stutibb@gmail.com)

[\*Note from HIFA moderator (Neil PW):  
CBR = Community-Based Rehabilitation  
CBID = Community-Based Inclusive Development  
PwDs = People with Disabilities]

## CHWs (21) What are your thoughts on the Guideline? (12) The career lifecycle of a CHW

5 June, 2019

Hi HIFA,

Thanks for starting this useful discussion on the WHO's CHW Guideline and recommendations.

When I first read through it, I began mapping out each of the recommendations to the career lifecycle of a CHW. This later turned into the attached infographic [\*see note below] that can be useful to map out at what stage of a CHW's career the WHO recommendations would take place.

Some more thoughts about the Guideline and recommendations can be found here: <https://hrh2030program.org/a-vision-for-professionalizing-community-heal...>

In particular, as we look at CHW programs and where they fit within health systems and existing health worker teams, these recommendations really need to be contextualized into national and local health systems. I have heard some people debate which recommendations should be implemented versus deprioritized; what I think is more useful is to consider which combination of recommendations would have the greatest impact. For

example, it is not useful to contract and pay a CHW but then not provide supportive supervision or support his/her enabling environment or hold him/her accountable for a reasonable scope of work. Likewise, the new CHW programs are an opportunity to transform pre-service education - many CHWs in LMIC settings have been trained through a patchwork of donor-supported trainings and it is hard to know what their qualifications are / the quality of the training, and what performance support is needed to ensure they provide quality health prevention, promotion, curative, palliative, and/or referral services.

In addition, I think that we have a lot more to learn about opportunities within the community health labor market. How can we promote career development of young CHWs who are committed to their communities' health but want to continue their education and advance within the health sector? What are viable CHW career paths? While CHW professionalization and recognition is essential for SDGs and promoting decent work, there may inevitably be community health volunteers who continue to provide support in their communities on an ad-hoc, part-time basis. What do we, as a global health community, do to harness and appropriately recognize their roles as well?

I look forward to continuing the conversation!

Thanks,

Rachel

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HIFA profile: Rachel Deussom is a Health Workforce Officer, CapacityPlus with IntraHealth International, USA. Her professional interests are human resources for health (HRH), mHealth, M&E, MNCH, health information systems and midwives. rdeussom AT intrahealth.org

[\*Note from HIFA moderator (Neil PW): HIFA does not carry attachments but the infographic can be seen as part of the blog in the above URL]

## CHWs (22) What are your thoughts on the Guideline? (13)

6 June, 2019

I think there is ambivalence in the guidelines.

On the one hand it talks of the importance of 'integration' within the health system

On the other hand it talks of 'supportive supervision' - without in any way defining who these supervisors are from or report to.

CHWs remain in a silo in too many health systems

My observation is that to be effective they MUST be an integrated part of the district health team.

Keeping children with diarrhoea OUT of hospital ought to be as important to the District Medical Officer as treating them in hospital.

Providing essential antenatal care in the community and identifying possible complications ahead of time is far better than receiving emergency presentations at the hospital at 3am in the morning

Helping old people manage their diabetes in the community is far better than having to cope with someone presenting with a gangrenous foot and associated complications in hospital.

In short, public health imperatives should be as important to the district physicians and nurses as treating the patients who present.

If CHWs are recognised as 'real' health professionals, integrated into the district health team (and remunerated) - then progress can and will be made.

Thank you

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HIFA profile: Bryan Pearson was editor/publisher of Africa Health journal for 40 years before passing ownership across to ACHEST in Kampala. He now works as a freelance consultant on health and associated issues; as well as tending a mango and pineapple farm in Ghana's Volta Region.

## CHWs (23) Selection, training and certification: a global North study

6 June, 2019

Hi All,

The Journal of Health Affairs had an interesting article on home and community-based health aides in the U.S. The article looks at income, selection, training, certification and supervision. One of the reasons the CHW Guideline is so relevant is that issues for community health workers transcend socio-economic status and national boundaries. What do you see as some of your country's challenges in the areas of selection, training and certification? Please let us know where your work is concentrated and whether you have observed best practices.

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00021>

Home health and personal care aides are one of the largest groups of health care workers in the US, with nearly three million people providing direct care for people with serious illness living in the community. These home care workers face challenges in recruitment, training, retention, and regulation, and there is a lack of data and research to support evidence-based policy change. Personal care aides receive little formal training, and they experience low pay and a lack of respect for the skill required for their jobs. High turnover and occupational injury rates are widely reported. There is little research on the factors associated with higher-quality home care, the extent to which worker training affects client outcomes, and how regulations affect access to and quality of home care. Health care leaders should seek to fill these gaps in knowledge, support the establishment of training standards and programs, implement Medicaid reimbursement strategies that incentivize improvements in pay and working conditions,

reform regulations that now prevent the full utilization of home care workers, and create sustainable career pathways in home care policies.

Kind regards,

Catherine

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## CHWs (24) Role of CHWs in disability and rehabilitation (5)

6 June, 2019

Dear HIFA Colleagues, I also whole heartedly support the integration of CBR into Primary Health Care (PHC), and add to the Job description of CHWs.

There are two points which should be taken into consideration as follow:

- 1) the size of the population of catchment area of CHWs should be reduced,
- 2) a skillful mid level technical person on CBR should be added to the supervisory team of the CHWs at the Community Health Center.

Supportive reasons for the integration is cost effectiveness and affordability, specially in LMIC, and the nature of comprehensiveness of PHC.

Kindest regards, Dr. Mohammad Ali Barzegar.

HIFA profile: Mohammad Ali Barzegar is an initiator of Primary Health Care in Iran since 1971, and Representative of People's Health Movement (PHM) Iran. His interest include 45 years of national & international experiences on PHC, Sustainable Development and Public Health. barzgar89 AT yahoo.com

## CHWs (25) Role of CHWs in disability and rehabilitation (6) Addressing the diversity of CHW roles

6 June, 2019

Dear Mohammad Ali Barzegar and all,

On behalf of the CHW working group, thank you all for your contributions so far. Please continue to share your thoughts, experience and expertise by email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

Dr Barzegar, you raise an important wider area of debate about pre-service training: "I also whole heartedly support the integration of CBR into Primary Health Care (PHC), and add to the Job description of CHWs."

As a personal comment, I am impressed - and daunted - by the huge diversity of roles that CHWs can potentially play in primary health care, and the evidence that supports this.

The selected highlights of the Guideline note: 'There is growing recognition that community health workers (CHWs) are effective in the delivery of a range of preventive, promotional and curative health services. They can contribute to reducing inequities in access to care.' The guideline emphasises maternal and newborn health, child health, communicable diseases, non-communicable diseases, trauma, surgical care, mental health, sexual and reproductive health... and they are also important in helping people to access health services and to advocate for their health rights.

<https://apps.who.int/iris/bitstream/handle/10665/275501/WHO-HIS-HWF-CHW-...>

This begs a number of questions: Should each and all of these (not to mention rehabilitation) be added to the job description of CHWs? Should every element be included in the pre-service training of every CHW?

As our discussion moves towards selection, training and certification of CHWs, I invite comments on the breadth and depth of pre-service training that CHWs need, and to what extent such training should be standardised.

The Guideline addresses these questions:

'For CHWs receiving pre-service training, should the curriculum address specific versus nonspecific competencies? For CHWs receiving pre-service training, should the curriculum use specific delivery modalities versus not?'

The Guideline is unequivocal: 'The scope and roles of CHWs vary substantially across countries and CHWs, hence it is not possible to standardize the scope of pre-service education and contents of curricula.... The most appropriate contents of CHW training should be established at the country level (either in a national or subnational context) on the basis of local needs and circumstances.'

This is reflected in Recommendation 3 of the Guideline: 'WHO suggests including the following competency domains for the curriculum for pre-service training of CHWs, if their expected role includes such functions.'

On the other hand, the Guideline says: 'A broad set of core competencies may ensure that all CHWs have the basic skills necessary to adequately carry out their role.'

If I am interpreting this correctly, there is a shift from the idea of a primarily universal curriculum for CHWs towards one where pre-service training is tailored according to a country's needs.

This also has the advantage of addressing unrealistic expectations of individual CHWs to become competent in an unfeasibly wide range of tasks. Furthermore, it opens up the option for CHWs who have completed basic training (in line with national priorities) to receive further modular training in specific areas of health (in line with the CHW's interests) and thereby become specialised CHWs.

There are caveats, however. As the Guideline notes, 'CHWs are often trained unimodally to specialize in the care of a single patient condition, such as diabetes or HIV' (this is also the case in training of lay health workers in mental health). So in some situations there may be a case for permitting such specialist training without the need for prior general CHW training.

Also, there would need to be a balance between general and specialist training. 'A model based exclusively on specialised CHWs might carry risks of fragmentation of care, resulting in gaps in service provision and inefficiency.'

Many thanks, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (26) What do policymakers think of the CHW Guideline?

7 June, 2019

Dear HIFA colleagues,

This week we have been discussing Question 1: What are your thoughts on WHO's CHW Guideline? What questions do you have about it?

I would like to invite policymakers on HIFA to comment, especially those who in ministries of health in LMICs, for whom the Guideline is largely targeted. I also invite comment from those who work \*with\* policymakers, including (inter alia) researchers, public health professionals, representatives of the health professions, health advocates, and CHW leaders.

What aspects of the Guideline do you find most useful? Does the Guideline ask the right questions? Are there other questions you would like to see addressed?

In what ways do you see the various recommendations in the Guideline being considered in your country?

There are 18 recommendations in the Guideline. Recommendation 1 and 7 are divided into three and two recommendations, respectively, making a total of 18 Recommendations.

Recognising that in many cases the certainty of the evidence is low or very low, and considering that the most appropriate strategies may vary by context, the vast majority (14/18) of the recommendations are 'Conditional'.

'For most recommendations a low or very low certainty of the evidence translated into conditional recommendations. For a few recommendations, the GDG made a strong recommendation despite the low or very low certainty of the evidence, taking into account other factors, including health workers' rights and equity and gender considerations. In the cases where strong recommendations were proposed despite a low or very low certainty of the evidence, the GDG took an explicit vote, the outcome of which is reported in the sections referring to the specific recommendations. In the cases when voting took place, a majority was defined as 80% or above of the voting members in attendance at the

GDG meeting.' (Guideline, p27)

As Dr Tedros says in the Foreword, the Guideline makes 'pragmatic recommendations on how to improve and strengthen their selection, education, deployment, management, supervision, career advancement, community embeddedness and system support'.

In line with guideline protocols introduced by WHO a few years ago, the Guideline includes a section on Guideline Use: 1. Plans for guideline dissemination and 2. Plans for guideline adaptation, implementation and evaluation.

With regards to the latter, the Guideline states:

'In order to maximize the opportunities for the guideline to be implemented, it will need to be adapted and contextualized, including through a number of derivative products made available in relevant languages to promote uptake at country level. Beyond the adaptation, simplification and development of user-friendly summaries of messages, a range of accompanying activities will be considered and implemented, subject to resource availability. Some of these activities might be directly implemented and supported by WHO, others by or in collaboration with other agencies and partners involved in the Global Health Workforce Network CHW hub, or other institutions. A non-exhaustive and non-binding list of activities that will be considered includes...

[there follows an impressive list of activities including:

- development of a dedicated online portal;

- a one-stop shop suite of derivative products, including toolkits, to ensure the guideline is easily comprehensible and is taken up by stakeholders (this will include translation of the guideline into the WHO official languages), with the assets filtered through different lenses by audience (such as funders, implementers);
- a series of webinars;
- regional workshops bringing together regional and country champions and stakeholders involved with CHWs to assess which countries would election of a few countries in which to prioritize policy dialogue and capacity-building activities, supported by drafting a regional and country implementation map;
- meetings of country stakeholders involved with CHWs to present the guideline and design a partner support plan (agree on roles and responsibilities and contributions);
- a workshop with government stakeholders (ministry of health, ministry of finance, development partners) for awareness raising and country mapping of existing CHW situation and policies, to create a baseline and, potentially, a roadmap for uptake of the recommendations, and to support the ministry of health in advocacy with the ministry of finance;
- a self-assessment tool based on the recommendations of the guideline that supports countries in developing baseline information related to CHWs, and that can be used to monitor and evaluate implementation of policies and programmes aligned with the recommendations.]

This section reflects the huge size of the challenge (and opportunities) ahead in terms of supporting use of the Guideline in promoting positive change in national policies on CHW deployment in the wider framework of health workforce development. The work has just begun, and HIFA is privileged to play our small part to maximise its impact.

The Guideline is available here in several languages, in both full and selected-highlights versions. <https://www.who.int/hrh/community/en/>

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (27) What are your thoughts on the Guideline? (14)

7 June, 2019

I totally agree with you Bryan [Pearson, UK], as long as we don't integrate the CHW in the health care system, we continue to incur higher and un-necessary costs of treatment of ailments which would be otherwise prevented at community level.

There needs to be a minimum level of education though for the CHW.

Happy

HIFA profile: Happy Annet Walusaga is a community linkages coordinator at Makerere Joint AIDS Program in Uganda. Professional interests: breaking down medical concepts to understandable units by the local community members in my region, hence empowering the community with knowledge to prevent HIV transmission, treatment and care, fight stigma, understand and promote as well as preventing and managing other diseases of public health importance in an all-inclusive community. email address: happyannetw AT yahoo.com

## CHWs (28) What are your thoughts on the Guideline? (15)

7 June, 2019

Dear Colleagues:

6 June, 2019

A few thoughts on community health workers:

1. Were primary health care for all accepted as the essential, most cost beneficial and humane way of keeping us healthy, especially in societies in

demographic transition, community health workers will be needed to carry out, under supervision, the day to day basic curative and preventive activities. The reason for this is that there will never be enough trained nurses much less doctors willing to live & work in the rural areas, peri urban slums, and inner city barrios, where most of the most poor and needy reside. (And even if there were, those most-in-need communities couldn't afford to pay for such highly trained personnel).

2. Because training cannot overcome character deficits, CHW selection must include community input, so as to ensure that they are inherently caring, linguistically and socially acceptable and have the kind of ties to the community that will keep them there for long enough to settle in, learn their trade and faithfully serve their people. Other selection criteria like trainability, capacity to overcome superstition and habit, and ability to accept supervision and literacy should be the purview of health professionals.

3. Since community workers, however intelligent, are rarely educated enough to understand the scientific bases for sterile technique, nutrition science, bacteriology versus virology, immunology, acid base balance, genetics, hyper- and hypo-tension, etc., etc., (and since the quality of practice of even highly trained doctors deteriorates without supervision or peer pressure!), they need regular supervision, continuing education and, for those with potential, some kind of career ladder, so as to maintain standards and avoid "burn-out".

4. This supervision should be shared by the district health team and by the health committee of the target community since only the latter can reliably assess whether the CHW is really reaching out and getting out to those most in need, and whether they really care about what they are doing!

5. Every primary care team needs to meet regularly, (at least every two weeks), and the CHW's need to be part of that meeting so that a) their contributions are recognized, b) their observations recorded and respected, and c) so that they learn and develop team loyalty.

6. If/when their supervisors are absent, there needs to be a well planned & rehearsed referral system in place so that emergencies and urgencies get to a higher level of health care before anyone's life or health is imperiled.

Allowing deaths or serious deterioration of patients under CHW care to occur (and then blaming them for this) cannot be permitted!

Respectfully,

Nicholas Cunningham MD Dr P.H.

P.S. to Byan Pearson (my old friend from Ilesha!): I believe that CHW's should be considered "para'professionals" not professionals; they have their expertise, and in time come to know their communities far better than the professionals! But, I believe that credentials matter... and that the educated health professionals need to be respected for what they know, teach and practice!

HIFA profile: Nicholas Cunningham is Emeritus Professor of Clinical Pediatrics & Clinical Public Health at Columbia University, New York, USA. He is interested in International Primary Maternal and Child Health Care, community owned, professionally overseen, and supported by \$/power interests, incorporating integrated cure/prevention, midwifery/child care, child saving/child spacing, nutrition/infection, health/education (especially female), monitored but not evaluated for at least 5-10 years, based on methods pioneered by David Morley at Imesi (Nigeria) and by the Aroles at the Jamkhed villages in Maharashtra State in India. Totatot AT aol.com

## CHWs (29) Role of CHWs in caring for older persons

7 June, 2019

I did not see the guidelines on CHW but I agree with the sentiments that they need to be contextualized even within countries and between programmes. I am especially interested in the role that CHWs can play in health of the rising number of older persons, given that the nature of their health and medical conditions (including mental health and disability), and the WHO advisory to restructure services from hospital based to community based. I would love to work with those interested in this area, especially to design, develop and implement a training curriculum and other support tools.

Stephen Okeyo, Kenya

HIFA profile: Stephen Okeyo is the Dean at Great Lakes University of Kisumu-Tropical Institute of Community Health and Development (TICH) in Kenya. Professional interests: Reproductive Health; Public/Community Health (community based approaches); Health Policy and Systems; Quality of care; Academic Management and Leadership; Research Email address: okeyo2012 AT gmail.com

## CHWs (30) Selection of CHWs for pre-service training (1)

8 June, 2019

Dear HIFA colleagues,

Thank you all for your contributions to the discussion so far! By sharing your thoughts, experience and expertise you are assisting WHO, ministries of health and others in our common purpose to empower CHWs to accelerate progress towards universal health coverage and SDG3 health targets. The email address for contributions is [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

We now enter our second week and we turn to Recommendation 1 in the WHO Guideline. Recommendation 1 is in three parts and suggests certain criteria to use - and not to use - for selection of CHWs.

### RECOMMENDATION 1: SELECTION FOR PRE-SERVICE TRAINING

#### Recommendation 1A

WHO suggests using the following criteria for selecting CHWs for pre-service training:

- minimum educational level that is appropriate to the task(s) under consideration;
- membership of and acceptance by the target community;
- gender equity appropriate to the context (considering affirmative action to preferentially select women to empower them and, where culturally relevant, to ensure acceptability of services by the population or target group);
- personal attributes, capacities, values, and life and professional experiences of the candidates (e.g. cognitive abilities, integrity, motivation, interpersonal skills, demonstrated commitment to community service, and a public service ethos).

Certainty of the evidence - very low. Strength of the recommendation - conditional.

#### Recommendation 1B

WHO suggests not using the following criterion for selecting CHWs for pre-service training:

- age (except in relation to requirements of national education and labour policies).

Certainty of the evidence - very low. Strength of the recommendation - conditional.

#### Recommendation 1C

WHO recommends not using the following criterion for selecting CHWs for pre-service training:

- marital status.

Certainty of the evidence - very low. Strength of the recommendation - strong.

QUESTIONS FOR DISCUSSION: How do these criteria relate to current practice in your country/experience? Are these criteria implementable in your country/experience?

(Note: The above questions are suggestions only. Feel free to ask your own questions. We encourage contributions on any aspect of CHWs at any time.)

The Background, Rationale, Summary of evidence, Interpretation of evidence, and Implementation considerations for this Recommendation are provided on pages 32-35 of the full version of the Guideline, which can be freely downloaded

here: <https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-en...>

Please send your contributions to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

Many thanks, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (31) A message from our child health forum CHIFA

8 June, 2019

[Note from HIFA moderator (NPW): Our discussion on CHWs is taking place on all six HIFA forums, in English, French, Portuguese and Spanish (see below on how to join them). The message below was posted today on our child health forum CHIFA]

Dear Neil, I wrote to you personally about my dis-agreement in respect of any program concerning CHWs. You suggested to me to write in CHIFA/HIFA.

I wrote about it in the past, now I do telegraphically.

- 1) CHWs are not supported by their communities. So far nobody wrote a convincing paper/letter/study where it is stated beyond any doubt that their community supported(\$) the work of CHWs and for long.
- 2) CHWs are neither supported(\$) by Governments. So far governments pay for their health workers that are officialy trained, wear a uniform, work in the thousand rural dispensaries/health centres/hospitals. This personnel is the one that communities recognized as their health providers, from ever. CHWs just came 'recently' brought forward by foreign INGOs that like the idea of their service and support(\$) them.
- 3) the idea of having CHWs originates from the love of PHC (primary health care), that was an excellent move in 1975, resisted for years but today has died, replaced by privatisation of services and market.

Suggestion.

Let's concentrate efforts and support(\$) to the current health workers, those with a uniform, with drugs to prescribe. Let's help them to deliver a service of PHC and not simply prescription of drugs.

They are supposed to visit their communities, to talk with them, to assist children and mothers, to promote hygiene and good sanitation. Some do it

despite the hardship and isolation they face.

After all they 'belong' to the community not less than CHWs, moreover they are regularly paid by their governments through tax collection. They are sustainable and long lasting...not certainly the CHWs.

Greetings from Dodoma

Massimo Serventi

Pediatrician

CHIFA profile: Massimo Serventi is a long-standing Pediatrician working in Africa since 1982. He currently works on a volunteer basis in an excellent missionary/credited hospital in north Uganda, St. Mary's Hospital-Lacor-GULU. He has worked for several NGOs in 6 African/2 Asian countries. His interests include clinical and community pediatrics, adherence to clinical guidelines and school education as the major determinant of good health. massimoser20 AT gmail.com

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Join HIFA-Zambia: <http://www.hifa.org/join/join-hifa-zambia>

## CHWs (32) Compilation of messages during week 1

8 June, 2019

Dear HIFA colleagues,

Please find here a compilation of messages during week 1:

[http://www.hifa.org/sites/default/files/articles/CHW\\_discussion1\\_compila...](http://www.hifa.org/sites/default/files/articles/CHW_discussion1_compila...)

We hope you find this useful to review and contribute to the ongoing discussion.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (33) Selection of CHWs for pre-service training (2)

9 June, 2019

Dear HIFA colleagues,

We invite you to comment on Recommendation 1 of the CHW Guideline, which relates to selection of CHWs for pre-service training:

'CHW programmes should select CHWs based on criteria including educational level, membership of and acceptance by the community, personal attributes and gender equity.'

WHO Guideline - Selected

Highlights: <https://apps.who.int/iris/bitstream/handle/10665/275501/WHO-HIS-HWF-CHW-...>

QUESTION: Recommendation 1 of the CHW Guideline (below) suggests certain criteria to use and not to use for selection of CHWs. How do these criteria relate to current practice in your country/experience? Are these criteria implementable in your country/experience?

### RECOMMENDATION 1A

WHO suggests using the following criteria for selecting CHWs for pre-service training:

- minimum educational level that is appropriate to the task(s) under consideration;

- membership of and acceptance by the target community;
- gender equity appropriate to the context (considering affirmative action to preferentially select women to empower them and, where culturally relevant, to ensure acceptability of services by the population or target group);
- personal attributes, capacities, values, and life and professional experiences of the candidates (e.g. cognitive abilities, integrity, motivation, interpersonal skills, demonstrated commitment to community service, and a public service ethos).

Certainty of the evidence - very low. Strength of the recommendation - conditional.

#### RECOMMENDATION 1B

WHO suggests not using the following criterion for selecting CHWs for pre-service training:

- age (except in relation to requirements of national education and labour policies).

Certainty of the evidence - very low. Strength of the recommendation - conditional.

#### RECOMMENDATION 1C

WHO recommends not using the following criterion for selecting CHWs for pre-service training:

- marital status.

Certainty of the evidence - very low. Strength of the recommendation - strong.

The Guideline highlights the need to:

- Specify minimum educational levels;
- Require community membership and acceptance;
- Consider personal capacities and skills; and

- Apply appropriate gender equity to context.

(It's interesting to note the words '\*require\* [my emphasis] community membership and acceptance', which implies a strong recommendation, and yet this aspect of selection is under Recommendation 1A, where the recommendation is 'conditional'.)

The full text of the Guideline

[\[https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-en...](https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-en...) provides background to the Selection issues:

'Effective CHW recruitment and selection for pre-service training may improve CHW performance and the quality of services delivered. Selection criteria may vary depending on which sociodemographic characteristics are most relevant to the community or to the intervention being delivered. For large-scale CHW programmes, criteria considered typically include age, gender, literacy level, educational attainment, marital status and geographical location (31). The active involvement of the community being served in the recruitment of CHWs is typically assumed to ensure that the CHW is trusted and accepted into the community.'

'The Guideline Development Group (GDG) considered the benefits and harms of having selection criteria for enrolment of candidates in pre-service education to become CHWs. The GDG consensus view was that selection of the most appropriate people as CHWs is crucial to the success of a community health intervention. The choice of criteria to be adopted, however, depends on the evidence of effectiveness, as well as broader policy considerations related to values and preferences, which may vary considerably across different contexts.'

'Furthermore, the GDG noted that this recommendation touches on a human rights dimension, the fundamental right of equality of opportunity and treatment in employment or occupation...'

We look forward to your contributions. Please send by email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (34) What are your thoughts on the Guideline? (16)

9 June, 2019

Dear Neil and HIFA colleagues,

Just managed to catch up on the interesting discussions of the week today and realised we are moving on to the next part of the discussion. If I am not too late to contribute to the thread [\*see note below], I would like to share a few thoughts that occurred to me as I went through the vibrant discussion on HIFA and CHIFA.

a) One significant area to work on during the revision of the guidelines on Health policy and system support to CHWs would be on the modality of integration of the CHW group into the Health systems of countries.

- A prerequisite for integration would be that CHWs must be remunerated commensurate with their work in the community in a well delineated linkage to the Health Centres whose personnel will likely provide the guidance and supervisory support that can help them perform better.

My personal view based on the observations regarding the different cadres supposed to work at primary and secondary levels is that in the absence of guidelines, there is already too much of fragmentation of care even amongst the uniformed staff for primary care within the Government funded primary care. Those familiar with work in India know that Health is a state subject - with provincial or district health administration having directives from the state Government- , so when it comes to National programmes or Centre prioritised work such as Maternal and Child health, there is some confusion between the responsibilities and accountability of the different members involved (Auxilliary Nurse Midwives vis-a-vis ASHA Workers, our equivalent of accredited CHWs).

b) I came across a viewpoint on CHIFA (Massimo) that the existing health workers within the System can be promoted to do much of what is expected of the CHWs, if only Governments cared to have in place some quality standards and good remuneration policy. While we all agree on the existing Primary care health staff to have better support including remuneration - a prerequisite to even expect quality performance within the public Health System - , WHO's policy guidelines must not be seen as supplanting the current system but as strengthening the areas where we see gaps, if not gaping lacunae. Dr. Joseph Ana's response yesterday well encapsulated the context and rationale for working towards optimising the CHW program. I can perhaps add one point now - something I was keeping for discussion in the following week but may be in context here - and that concerns a distinct feature that must differentiate a CHW from all other uniformed personnel: He or She must belong to the community settings in the neighborhood of the Primary Healthcare facility i.e. be a resident of the catchment areas or the geographical vicinity of the centres serving the target population.

c) Would integration of CHWs within the Health System be better if they were a salaried group within Primary Health Centres linked to the District Healthcare Facility providing specialist services and training? Depends on how well organised the Health System is in terms of levels of Care and administrative support for UHC.

There were a couple of expert comments related to the lack of a sustainable career pathway for Home care workers and Nursing aides (who often have some informal on-the-job training). I think so too. Again ,a case for formal training (mentored by the Senior Nursing staff of PHCs?) with certification after a short period of training can make them - and the people they serve - feel secure.

d)Lastly, to the part I feel strongly about:

- I am fully in agreement with Dr.Barzegar's recommendation that there be a mid-level technical person with experience in CBR to guide and supervise CHWs for Disability-related work or rehabilitation in resource constrained settings.

- The pre-service training can include some orientation to all the areas in which CHWs within the current health systems play an important role and in addition, have a disability-specific module for her to work with a holistic approach that addresses prevention, Health promotion, caregiving, referral support and long-term rehabilitation in the framework of Community based inclusive development.

I also feel that a broad set of core competencies (recommendation 3 of the guidelines) can ensure their integration into the team operating at Primary Health care level. Important if the common thread that runs through the discussion is to ensure UHC. Just as with doctors, who have a broad understanding of different areas they study during MB,BS., with expertise that stands them well for primary Healthcare, but may still require additional studies for unimodal specialisation for secondary / tertiary care settings, so also for CBR (which to my mind is a specialised area even though it does not get recognised as such because one is not getting linked to a level higher in heirarchy.).

I would like to remind all here that we are speaking of CBR workers as a cadre of CHWs strengthening services within the System rather than be the ones taking care of all (not a context of where there is no doctor).

Thanks and regards,

Sunanda

Dr. Sunanda K. Reddy  
Chairperson (Honorary), CARENIDHI  
Adjunct Faculty, SACDIR, IIPH Hyderabad  
Phone: +91-9818621980, +91-9560302666

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi,India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

<http://www.hifa.org/support/members/sunanda>

<http://www.hifa.org/projects/community-health-workers>

write2sunanda AT gmail.com

[\*Note from HIFA moderator (NPW): Thank you for your rich contribution, Sunanda. Contributions on any aspect of CHWs at any time are welcome.]

## CHWs (35) Selection of CHWs for pre-service training

### (3) Pre-service training

9 June, 2019

Given the selection criteria and the context within which CHWs are expected to work my thought is that pre-service training need to be general covering foundation competencies that can be agreed by consensus at country level. I further propose that in-service training can then focus on priority and common conditions that are encountered. In an earlier submission I had for example mentioned conditions of older persons whose design should include a shift from facility based to home and community based.

Okeyo

HIFA profile: Stephen Okeyo is the Dean at Great Lakes University of Kisumu-Tropical Institute of Community Health and Development (TICH) in Kenya. Professional interests: Reproductive Health; Public/Community Health (community based approaches); Health Policy and Systems; Quality of care; Academic Management and Leadership; Research Email address: okeyo2012 AT gmail.com

## CHWs (36) Community health worker saves lives

9 June, 2019

How fortuitous that Tropical Health should carry the report below about the usefulness of having Community Health Workers - CHW.

We had just been commenting on Mr Massimo's posting [on our sister forum, CHIFA] earlier today.

READ

Subject: [tropicalhealth] Community health worker saves lives

Reply-To: "Tropical Health Update" <[malaria@my.ibpinitiative.org](mailto:malaria@my.ibpinitiative.org)>

<https://www.malariamustdie.com/jean-boscoss-story>

“A community health worker called Markson, who had been trained by social justice organisation Last Mile Health in the diagnosis and treatment of simple malaria, pneumonia, diarrhoea and malnutrition, quickly transferred the boy and his mother to the clinic. Thanks to him, Patrick survived. He was lucky because Markson was able to identify and diagnose the complicated symptoms malaria, and acted quickly upon this.”

Community health worker Markson with a mother and her child

This one community health worker’s training and quick actions show how critical their role is in saving lives. “Many may think having a community health worker is a luxury, but that is false,” says Dr Niyonzima. “When community health workers are trained and supervised, and receive regular medical supplies and financial compensation, they do a good job. Their role needs to be integrated into primary healthcare systems and it would be a mistake to ignore this - the price is too high.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicem & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

## CHWs (37) Selection of CHWs for pre-service training (4)

9 June, 2019

The recommendation that CHWs have a "minimum educational level that is appropriate to the task(s) under consideration" is connected to so many other aspects of CHWs' success.

As the guideline rightly points out, "While a higher level of prior education may be associated with improved knowledge and performance, attrition (due to better and more diverse work opportunities) might be higher among more educated CHWs" (pg 34). There is a level of intimacy and trust required for CHWs to be effective, especially as they often work out of people's homes. Of course competency is important, but trust and education level are not necessarily correlated.

However, how much education is required to complete the "task(s) under consideration"? It varies, but is usually centered around finishing some basic education, such as primary or secondary.

I have noticed in the research that CHWs work well with a defined set of services that they master. There seems to be a tipping point at which CHWs are too overloaded with health conditions to check on, and they become less able to reach people with the same frequency or efficiency. Are there any specific studies that have been done looking at this relationship? Or has anyone had experience with this at the national or sub-national level? And what happens when CHWs are recruited for certain tasks and then other responsibilities are added on? How has that changed the performance of CHWs in those instances, or the planning for selection/training in the future?

Thanks,

Amelia

HIFA profile: Amelia Plant is the Portfolio & Impact Manager at Preston-Werner Ventures, a San Francisco-based foundation looking to create scalable impact at the intersection of climate change and social justice. Amelia specializes in sexual reproductive health and rights, focusing on family planning information & access. She is currently based in Cairo, Egypt. She is a member of the HIFA working group on Family Planning and the HIFA wg on Community Health Workers.

<http://www.hifa.org/support/members/amelia>

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asiplant AT gmail.com

CHWs (38) One Million Community Health Workers  
(1mCHW)

9 June, 2019

Dear Neil and Massimo Serventi,

Sharing a weblink hoping you will find it useful as evidence, even though it may not be high on the hierarchy of evidence. The appendix is particularly about the evidence base.

An excellent project on scale, the 1 million Health workers project, shows the way.

However, my main reservations about saying it can be replicated to optimise CHW programs to meet the goal of UHC are twofold.

1. It had a huge budget (more than the annual health budget of many LMIC) that may pose a problem in sustainability when such an investment is not possible.
2. This Columbia University project was not built into the existing Health Systems in a way that we could say is cost effective.

Stand alone vertical programs in a project mode have good pre-job training, effective evaluation and monitoring mechanisms throughout the duration of the project, and above all, a decent remuneration to ensure there is no attrition in numbers. (The challenges will come to the fore once the external funding ceases).

Having said that, there are a lot of lessons for countries that wish to prioritise CHW programs to strengthen the efforts towards UHC.

Thanks and regards,

Sunanda

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots

convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

<http://www.hifa.org/projects/community-health-workers>

<http://www.hifa.org/support/members/sunanda>

write2sunanda AT gmail.com

[\*Note from HIFA moderator (Neil PW): The original message had an attachment. Attachments are not carried on HIFA. The document can be freely downloaded

here: [http://www.millenniumvillages.org/uploads/ReportPaper/1mCHW\\_TechnicalTas...](http://www.millenniumvillages.org/uploads/ReportPaper/1mCHW_TechnicalTas...)

## CHWs (39) What are your thoughts on the Guideline? (17)

9 June, 2019

Dear Hifa Members,

The current discussion on CHWs is increasingly gaining a lot of attention. However most of my thoughts and questions have been ably answered by Prof. Cunningham contributor (28). But all the same I wish to be educated on the following:

Has WHO prepared Modus to standardise training of these cadres, what about technical [technical?] issues Including confidentiality? I agree with some thought to get blessings the community this should include opinion leaders? Faith-based leaders should involved...

My other thought is that to what extent the would quacks would be prevented from masquerading? Integrating them into the main might create suspicion among some trained officers. My take on this they should be independent of each other from the main stream of the health system but treated as equal partner in providing healthcare services

Klc

HIFA profile: Kenneth L Chanda is Associate Consultant and Lecturer at National Institute of Public Administration where he is lecturing in Records Management. He is co-author of The development of telehealth as a strategy

to improve health care services in Zambia. Kenneth L. Chanda & Jean G. Shaw. Health Information & Libraries Journal. Volume 27, Issue 2, pages 133-139, June 2010. He recently retired as Assistant Medical Librarian at the University of Zambia. klchanda AT gmail.com

## CHWs (40) Selection of CHWs for pre-service training (5)

10 June, 2019

Kenya Experience with regards to WHO Guidelines on CHW selection criteria

### Recommendation 1A

Educational requirements include being literate and a secondary school leaver

Acceptability by the community is well emphasized, and culturally women are generally the majority

The personal attributes are generally perceived to contribute to acceptability by the community, but these are often NOT broken down to the specific elements. This is an area where research could generate better evidence for decision making, especially in understanding performance, motivation, drop out etc

### Recommendation 1B

Age does NOT feature at all in the selection criteria, but in practice within our cultural context age has an influence on social communication and may influence performance especially with regards to young persons discussing reproductive issue with older persons and vice versa. This is also an area where social research can generate more evidence

### Recommendation 1C

Marital status is NOT used as a criteria but in practice society/communities have perceptions, often misperceptions about being or not married, and this has implication for social communication. This may be confounded by age. Either way it has implication for acceptability and performance and in need of more evidence

In general, these WHO recommendations on selection criteria are implementable, and actually already being implemented to some extent.

okeyo

HIFA profile: Stephen Okeyo is the Dean at Great Lakes University of Kisumu-Tropical Institute of Community Health and Development (TICH) in Kenya. Professional interests: Reproductive Health; Public/Community Health (community based approaches); Health Policy and Systems; Quality of care; Academic Management and Leadership; Research Email address: okeyo2012 AT gmail.com

## CHWs (41) Selection of CHWs for pre-service training (6)

10 June, 2019

Dear Stephen Okeyo,

Thank you for sharing the Kenya experience with regards to WHO Guidelines on CHW selection criteria.

It would be interesting to hear from HIFA members the experience in other countries. Indeed, has anyone attempted a comparative study of the selection criteria for CHWs across different countries?

Also, I suspect there may be substantial variation within countries, especially perhaps between government-, NGO- and FBO-led (faith-based organisation) programmes?

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: [www.hifa.org](http://www.hifa.org)

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (42) BMJ: Primary healthcare is cornerstone of universal health coverage (1) PACK (Practical Approach to Care Kit) (4)

10 June, 2019

Dear HIFA colleagues,

'Global collaboration is also essential, including efforts by WHO and other leading global health organisations to develop standardised, evidence based tools and resources that support the implementation of effective, safe, and patient centred primary healthcare.'

Below are extracts from a new BMJ editorial by Agnes Binagwaho & WHO Director-General Tedros Adhanom Ghebreyesus, and a comment from me.

CITATION: Primary healthcare is cornerstone of universal health coverage

BMJ 2019; 365 doi: <https://doi.org/10.1136/bmj.l2391> (Published 03 June 2019)

BMJ 2019;365:l2391

Correspondence to: A Bingawaho [abinagwaho@ughe.org](mailto:abinagwaho@ughe.org)

'We must invest more in primary healthcare – and invest more wisely...

'We have already seen, in our own countries, how placing primary healthcare at the heart of all efforts to achieve universal health coverage has transformed population health. In Rwanda, 45 000 community health workers serve as the first point of contact for people needing healthcare; they are the functional link between communities and health facilities, such as hospitals. In Ethiopia, tens of thousands of health extension workers bring healthcare to villages and put communities in control of their health. In both countries, primary healthcare has been successfully tailored to local health priorities, as the World Health Organization recommends...

'Global collaboration is also essential, including efforts by WHO and other leading global health organisations to develop standardised, evidence based tools and resources that support the implementation of effective, safe, and patient centred primary healthcare...'

COMMENT: The authors highlight the importance of community health workers in the provision of primary health care and the achievement of universal health coverage. For me, this underlines the critical nature of WHO's CHW Guideline and how the international community interprets, considers and integrates (where appropriate) its recommendations. It is also vital that challenges such as national policy development and implementation are discussed sooner (including here on HIFA) rather than later, as well as questions around issues such as the parallel strengthening of the existing health workforce.

Perhaps it is helpful to keep our focus on understanding and progressively addressing the basic SEISMIC needs of \*all\* health professionals and paraprofessionals to maximise their ability to deliver the care for which they are trained. There can be nothing more demoralising and disempowering than to set high expectations and then expect these to be achieved with minimal support (<http://www.hifa.org/about-hifa/hifa-universal-health-coverage-and-human-...>). As I have suggested before on HIFA, health systems need to be health-worker-centred as well as people-centred.

Specifically the call 'to develop standardised, evidence based tools and resources that support the implementation of effective, safe, and patient centred primary healthcare' represents a direct call for increased investment in evidence-based tools such as PACK (Practical Approach to Care Kit), as described by HIFA members Joseph Ana, Tracy Eastman and others.

When we started HIFA in 2006 we set our sights on 'Health information for all by 2015'. We've since learned that this is a marathon, not a sprint. That said, we continue to move slowly but surely towards a world where every health worker will have access to the reliable information they need, in the language and format they need, to help inform better clinical decisions and better health outcomes.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global

community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (43) CHWs using WhatsApp

10 June, 2019

HIFA has previously successfully linked with community health workers interacting in local languages on WhatsApp in India and Uganda. We hope to replicate and extend this in the current discussion because it is vital we hear the voices of CHWs (if you are part of a CHW WhatsApp please let me know! [neil@hifa.org](mailto:neil@hifa.org) ). Below is a new study that looks at the role of WhatsApp in blended learning, peer support, and mentoring.

'In Zimbabwe, primary counselors (PCs) are a cadre of health worker that has been established to support task shifting, providing HIV testing and counseling (HTS) to adult, adolescent, and pediatric patients. This cadre of health worker is secondary school educated, a minimum of 25 years of age, and, in general, has no formal medical education prior to being employed as PCs. These health workers are the target audience for a blended learning course in HTS for children and adolescents...'

Citation and abstract below. Full text here: <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960...>

CITATION: Health worker text messaging for blended learning, peer support, and mentoring in pediatric and adolescent HIV/AIDS care: a case study in Zimbabwe.

V. Bertman Email author View ORCID ID profile, F. Petracca, B. Makunike-Chikwinya, A. Jonga, B. Dupwa, N. Jenami, A. Nartker, L. Wall, L. Reason, P. Kundhlande and A. Downer

Human Resources for Health 2019 17:41

<https://doi.org/10.1186/s12960-019-0364-6>

### ABSTRACT

Background: In sub-Saharan Africa, shortages of trained healthcare workers and limited resources necessitate innovative and cost-effective approaches for training, supervising, and mentoring. This qualitative case study describes participants' and trainers' perspectives and experiences with a text messaging component of a blended training course in HIV counseling

and testing in Zimbabwe, using minimal resources in terms of staff time and equipment requirements. This component included a whole-group discussion forum as well as two-person partner discussions designed to promote reflection and analysis, teamwork, and active learning.

Case presentation: The Ministry of Health and Child Care (MoHCC) of Zimbabwe collaborated with the International Training and Education Center for Health (I-TECH) on adaptation of a 5-day in-service training in HIV Testing Services for Children and Adolescents. The new 7-week blended format included in-person sessions, tablet-based self-study, and discussions using the text messaging application, WhatsApp. Between August 2016 and January 2017, 11 cohorts (293 participants in total) were trained with this new curriculum, incorporating text messaging to support peer-to-peer and work-based education.

Data collected included training participants' feedback, key informant interviews with the training team, and thematic analysis of WhatsApp messages from full-cohort discussions and a sampling of one-to-one partner discussions.

A total of 293 healthcare workers from 233 health facilities across all provinces in Zimbabwe completed the blended learning course. Participants strongly endorsed using WhatsApp groups as part of the training. In the whole-group discussions, the combined cohorts generated over 6300 text messages. Several categories of communication emerged in analysis of group discussions: (1) participants' case experiences and questions; (2) feedback and recommendations for work issues raised; (3) inquiries, comments, and responses about course assignments and specific course content; (4) encouragement; and (5) technical challenges encountered using the blended learning methodology. Case discussions were complex, including patient history, symptoms, medications, and psychosocial issues—child abuse, adherence, and disclosure.

Conclusions: Using text messaging in a communication platform that is an ongoing part of healthcare workers' daily lives can be an effective adjunct to in-service training, minimizing isolation and providing interactivity, supporting students' ability to fully integrate content into new skill attainment.

COMMENT (NPW): The full text includes two WhatsApp exchanges among CHWs (I would be interested to hear reactions from HIFA members on the content):

Participant 1: A girl 16 came at my clinic ...[her grandma] accuses her of having of sleeping with boys ...both parants died she went to her

stepmother who came with her at the clinic .she was crying .they came to the counselling room.i gave her tissues and offered thm seats ... she stopped crying .and said she want to be tested to prove her grandma wrong

we discussed about hiv .results outcome .she consented to be tested .i tested her and her result were negative ...

Participant 2: You need to discuss about SRH [sexual and reproductive health] issues its important she is sexual active

Participant 3: How about window period,Social welfare Childline,SRH,widen system,dig for more information.Not bad.

Participant 1: Guys help me what is perinatal

Participant 2: Death of the infant soon after delivery with 72 hours in Maternity.

Participant 3: Perinatal is not death.its a period immediately before and after birth

Participant 3: Usually between 20-28 weeks of pregnancy to 4\_6weeks after birth [...]

I have invited the authors to join us.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (43) Integration of Ayurveda and Homeopathy practitioners?

10 June, 2019

Hi,

Further to your mail about choosing CHW, there are many BAMS (Ayurveda) and BHMS (Homeopath) doctors in rural India doing private practice.

Can we integrate them to such services? It would help if these practitioners are aligned with the thought process and goals of WHO, so as to achieve harmony in the management of diseases and preventive strategies.

I agree with Dr. Reddy's observations, that the program would work better if integrated into existing system.

Regards,

Dr. Narendra

HIFA profile: Narendra Javadekar is a physician and health economist with RESPIRE in India and has a professional interest in internal medicine, health economics, and public health. Email address: narenjavdekar AT yahoo.co.in

## CHWs (44) Reflections on CHW Discussion Week 1

10 June, 2019

Within the comments of the overall WHO guideline this past week, there has been a tension between the de facto acceptance of CHWs within the health system and practical considerations of exactly what their role should be.

Rachel inquired on June 5th, "How can we promote career development of young CHWs who are committed to their communities' health but want to continue their education and advance within the health sector? What are viable CHW career paths? While CHW professionalization and recognition is essential for SDGs and promoting decent work, there may inevitably be community health volunteers who continue to provide support in their communities on an ad-hoc, part-time basis. What do we, as a global health community, do to harness and appropriately recognize their roles as well?"

On June 6th, Bryan added, "If CHWs are recognised as 'real' health professionals, integrated into the district health team (and remunerated) - then progress can and will be made."

Finally, on June 8th, Massimo pointed out, "So far governments pay for their health workers that are officially trained, wear a uniform, work in the thousand rural dispensaries/health centres/hospitals. This personnel is the one that communities recognized as their health providers, from ever. CHWs just came 'recently' brought forward by foreign INGOs that like the idea of their service and support(\$) them."

As you can see, our HIFA network is split on what "community integration" should look like -- prioritization of government health workers, total acceptance of CHWs, or something in between.

A few reflections:

1. CHWs, in one form or another, have been around for over half a century (and probably longer). China's first CHWs from the 1950s were called "barefoot doctors" ( <https://www.who.int/bulletin/volumes/86/12/08-021208/en/> ). CHWs were integral to the success of the Matlab, Bangladesh studies in the 1970s that helped to spread contraceptive use globally ( <https://www.icddr.org/research/platforms/field-sites/more-on-matlab> ). There are numerous other examples as well. We cannot therefore contend that CHWs "just came 'recently' bought forward by foreign INGOs."

2. However, Massimo's point is important -- what is the effect of the existence of CHWs within the flow of the health workforce? As Rachel asked, how do we "harness and appropriately recognize" those CHWs who "continue to support in their communities on an ad-hoc, part-time basis"? Is there simultaneously space for those CHWs who want opportunities for career advancement and those that enjoy the status of serving the community in limited ways? If career advancements are provided for CHWs, does that disrupt the country's traditional medical education system?

These questions reminded me of Luis Tam and Muluken Melese's April 2019 piece in John's Hopkins' Global Health NOW Newsletter ( <https://www.globalhealthnow.org/2019-04/community-health-workers-and-vol...> ). They envision a primary health care model based on their work in rural Peru and Ethiopia, in which "government-paid, full-time CHWs providing comprehensive services to a given population, with a primary health center hub as the base of operations. Each CHW, in turn, would lead a team of part-time community health volunteers providing limited health education and referral services?such as maternal and newborn health,

nutrition, hygiene, tuberculosis, malaria, and HIV/AIDS?to a small number of neighboring families.

These are the kinds of discussions that HIFA is perfect for -- sifting through the general guidelines and sharing contextual learnings that are may or may not be applicable to all.

Amelia

HIFA profile: Amelia Plant is the Portfolio & Impact Manager at Preston-Werner Ventures, a San Francisco-based foundation looking to create scalable impact at the intersection of climate change and social justice. Amelia specializes in sexual reproductive health and rights, focusing on family planning information & access. She is currently based in Cairo, Egypt. She is a member of the HIFA working group on Family Planning and the HIFA wg on Community Health Workers.

<http://www.hifa.org/support/members/amelia>

<http://www.hifa.org/projects/family-planning>

asiplant AT gmail.com

## CHWs (45) Selection of CHWs for pre-service training (7) 10 questions on selection of CHWs

10 June, 2019

Dear HIFA colleagues,

Thank you for your contributions to the discussion and welcome to those who have joined us in the past few days.

Recommendations 1A, 1B and 1C of the new WHO guideline (Health policy and system support to optimize community health worker programmes) make a number of suggestions on selection of CHWs for pre-service training:

<http://www.hifa.org/dgroups-rss/chws-30-selection-chws-pre-service-train...>

Our headline question for this week is: How do these criteria relate to current practice in your country/experience? Are these criteria implementable in your country/experience?

We invite you to consider specific aspects of this important issue. For example:

1. What criteria do you feel are important in the selection of community health workers and why?
2. What CHW selection criteria are used in your country or program? Are they sufficient? What is your country/program doing to strengthen CHW selection? Do you have a successful practice to share?
3. What is the ratio of female to male CHWs in your setting? How does this ratio affect service delivery, especially regarding hard-to-reach population, such as youth-at-risk, substance users, or sex-workers?
4. The WHO Guideline recommends 'gender equity appropriate to the context'. How does your country/program manage gender (female/male) issues in the selection of CHWs? What more does your country/program need to do to improve CHW gender equity and service acceptability in your context? Do you have a successful practice to share?
5. When balancing the needs of your community and the level of education of the communities in which you work, what do you feel is the minimal educational requirement for a Community health Worker in your context? Do you have a successful practice to share?
6. What personal attributes are considered in the selection of CHWs in your country/program? Are these attributes sufficient to ensure a responsive and capable CHW workforce?
7. How are these attributes determined or measured in the selection process?
8. How might acceptability and respect for community health workers be promoted in your community?
9. What are the key work-related values and attributes required of community health workers? How are these attributes determined?
10. What are the restrictions in place (if any) for community health workers in your regions in relation to age, sex, marital status?

We look forward to hear your thoughts and experience on any of the above questions - or indeed on any aspect of selection of CHWs for pre-service training.

Please email your contributions as usual to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (46) Reflections on CHW Discussion Week 1 (2)

10 June, 2019

Amelia, thanks for sharing your reflections.

In Nigeria CHW are called Community Health Practitioners (CHP) comprising from the top: community health officers (CHO), then community health extension workers (CHEW) and finally junior community health extension workers (JCHEW).

They all have selection and training criteria, their curricula, and certification after training in schools / colleges of Technology. They have job descriptions linked to their respective curriculum and when employed have their career paths. The JCHEWs progress to CHEWs and then to CHO. They are full time or part time depending on the employer but they are all salaried in employment and are pensionable. Today they are essential and invaluable for the running of the primary health care tier of health service across the country.

Now, this is why in my first posting in this current discussion I reiterated my earlier view that definition of what CHW means varies as there are countries and so previous discussions had led nowhere because some members were discussing apples and others were talking about bananas, so to say.

For us therefore one of the major benefits of the WHO guideline under discussion is that it provides a unifying definition so that in the end every stakeholder will approach the subject matter from the same perspective.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

## CHWs (47) Selection of CHWs for pre-service training (8)

10 June, 2019

Comment: Nigeria already has clear criteria for the selection of community health practitioners (CHP) equivalent to community extension health workers, which the training schools and colleges use to admit students for pre service training to become registered in the CHW cadre by their regulatory body, the community health practitioners regulatory body (CHPRB): the cadre comprises Junior Community Health Extension Workers (JCHEWs) who receive certificates; Community Health Extension Workers (CHEWs) receive certificates and Community Health Officers (CHO) who receive diplomas. The training institutions also have curriculum for each of the cadre and during training the students take their practicals in the practicum sites (they shadow established staff). Nigeria also has guidelines called Standing Order for these CHW to use in the primary care clinics when they graduate. It is interesting to notice that in some countries Traditional Birth Attendants have been added to the cadre of CHWs, but not yet in most states of Nigeria. For now the opportunity offered by TBAs remain only partially tapped in Nigeria. For the question 'Are these criteria

implementable in your country/experience?' The answer is that the criteria in the WHO guideline are implementable in Nigeria because already there is a structured modus for selection.

But it must be stated that the criteria are implemented in difficult circumstances, due to the weakness of the health system in general. With a dearth of healthcare providers (physicians, nurses, midwives), JCHEWs, CHEWs and CHOs are critical to reaching patients including women and children in mostly rural, hard-to-reach areas. Nigeria has produced a Task Shifting Policy as an addition to the effort to deal with the dearth of the usual providers.

To meet the selection criteria, fully, Nigeria would need to include the 'gender equity' criterion as that is not a specific criteria for now.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

## CHWs (48) Selection of CHWs for pre-service training (9)

11 June, 2019

Dear Dr Joseph Ana and colleagues,

The Nigerian example appears to be close to what we want - CHWs not just being a part of the HS [health system] but also having some administrative

support and guided supervision from pre-service training to on-the-job experiential learning that is recognised.

Every country could plan to have junior extension workers drawn from the community.

It requires a flexible approach to contextualise to the local needs and, of course, political will to invest more for primary care.

Best regards,

Sunanda

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

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## CHWs (49) Training of CHWs

11 June, 2019

(with thanks to Health Informatics

Forum: <https://healthinformaticsforum.com/> )

Health Informatics Forum e-Seminar: Dr Niall Winters and Dr Judith McCool

In this webinar, recorded on 4 June 2019, HIFA CHW working group member Niall Winters (University of Oxford) discusses the use of mobile technologies can support the training and supervision of CHWs in LMICs, drawing on empirical work in Kenya and Uganda. He also examines on-going research into how the latest advances in artificial intelligence may be leveraged to support exploratory learning by CHWs during their day-to-day work. The work includes 'the ability to recognise naturalistic reactions in virtual reality spaces'.

This is followed by a presentation from Dr Judith McCool, New Zealand, on mHealth as it is evolving in Small Island Developing States (SIDS), the Pacific in particular.

You can follow Niall on Twitter: @nwin

Watch the video here:

[https://www.youtube.com/watch?v=06dq\\_S\\_RvTU](https://www.youtube.com/watch?v=06dq_S_RvTU)

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (50) Selection of CHWs for pre-service training (10)

11 June, 2019

Dear HIFA colleagues,

I reproduce below extracts from Recommendation 1 on the selection of CHWs for pre-service training. The Guideline can be downloaded here in

several languages: <https://www.who.int/hrh/community/en/>

### 7.1.2 RATIONALE FOR RECOMMENDATION

On balance, based on an assessment of the available evidence, the GDG experience, and a rights-based perspective, the GDG concluded that the potential benefits outweigh the harms when CHWs are selected for pre-service training based on personal attributes and capacities, such as motivation, integrity, interpersonal skills, memberships of and acceptability by the community, through community engagement in the selection process, and appropriate minimum education level. Conversely, the potential risks, particularly in relation to unfair discrimination, probably outweigh the potential advantages with regard to criteria such as age and, in particular, marital status. Given multiple barriers that women face to workforce participation and the resultant gender stratification inequities in the global health workforce, proactive policies are encouraged to promote gender equity and maximize women's participation in selection and recruitment. And in some circumstances - where the role and cultural norms of CHWs dictate - it may be appropriate to restrict selection to women, for instance where the delivery of reproductive and maternal health services is accepted by the communities only if the providers are female...

### 7.1.3 SUMMARY OF EVIDENCE

The systematic review (Annex 6.1)<sup>4</sup> addressing the following question - "In community health workers being selected for pre-service training, what strategies for selection of applications for CHWs should be adopted over what other strategies?" (34) - identified 16 eligible studies, of which three were quantitative (35-37) and 13 were qualitative (38-50). Ten of them referred to CHW programmes in sub-Saharan Africa, with three studies from South-East Asia and two from the Region of the Americas... Overall, the certainty of the evidence was rated as very low...

The stakeholder perception survey identified a high acceptability and feasibility of selecting CHWs on the basis of their personal attributes (for example, cognitive abilities and prior relevant experience) and membership of the target communities, but variable and uncertain feasibility and acceptability of selection based on level of education and, especially, age.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (51) Reflections on CHW Discussion Week 1 (3)

11 June, 2019

Thanks as always, Joseph, for your contribution.

One clarifying question: out of all of these different cadre of CHP/CHO/CHEW/JCHEWs in Nigeria, which are based in the communities they are from? You said they have training in schools/colleges of Technology. I assume that these are in larger metropolitan areas and not in rural villages? And are all of them going door-to-door, or some are based at health centers?

Nigeria and Ethiopia (and other countries I assume) have these tiered levels of CHWs. That surely seems like the way to go, albeit slight differences based on context. Are there resources/articles comparing these models? Perhaps CHW Central has some good examples they can point us toward in order to learn more?

HIFA profile: Amelia Plant is the Portfolio & Impact Manager at Preston-Werner Ventures, a San Francisco-based foundation looking to create scalable impact at the intersection of climate change and social justice. Amelia specializes in sexual reproductive health and rights, focusing on family planning information & access. She is currently based in Cairo, Egypt. She is a member of the HIFA working group on Family Planning and the HIFA wg on Community Health Workers.

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## CHWs (52) Stakeholder perception survey

12 June, 2019

As part of the development of the WHO CHW Guideline, 'a stakeholder perception survey was conducted to assess the acceptability and feasibility of the policy options under consideration in the guideline by stakeholders, with a view to increasing uptake and use of the emerging recommendations'.

Below is a summary of this from the Guideline:

A total of 96 submissions were obtained, with representation largely from policy-makers, planners, managers and researchers involved in the design, implementation, monitoring and evaluation of CHW programmes. The majority of the respondents were from the African Region; a limitation was that CHWs themselves were not adequately represented in this group. All outcomes of the CHW interventions were deemed to be at least important and several were rated as critical. The most critical outcomes were increased health service coverage and improved quality of health services provided by CHWs. Most of the health policy and system interventions under consideration in the guideline were also deemed to be acceptable and feasible for implementation. Acceptability and feasibility were uncertain for a few interventions considered, such as the use of essential and desirable attributes to select CHWs for pre-service training; these included, for example, selecting CHWs on the basis of age and completion of a minimum secondary level of education. The findings of the survey - presented in Annex 5 - informed the development of evidence to decision tables and ultimately the recommendations by the GDG.

Annex 5 notes: 'The survey was disseminated in English and French languages to stakeholders through three major channels: WHO human resources for health contact list, the Health Information For All (HIFA) online platform, and participants at the 2017 Institutionalizing Community Health Conference held in South Africa in 2017.'

Our thanks to HIFA members who completed the survey. The potential population surveyed is in the 10s of 000s (HIFA-English alone has 11,500). Perhaps unsurprisingly (survey fatigue) this suggests a response rate of a fraction of 1 per cent.

On HIFA, we have found that dynamic interaction among a global, multidisciplinary community (thematic discussions, such as the one we are having now) can provide rich content and insights that cannot be obtained from static online surveys. Such interactions could play an important complementary role in addition to online surveys, as part of the guideline

development process. Perhaps there is a role for inclusion of thematic discussions on forums such as HIFA as part of the guideline development process (in selected cases)? I would be interested to hear from members of the CHW Guideline Development Group their thoughts on this.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (53) Selection of CHWs for pre-service training (11)

12 June, 2019

Recommendation 1 of the Guideline states

### RECOMMENDATION 1A

WHO suggests using the following criteria for selecting CHWs for pre-service training:

- minimum educational level that is appropriate to the task(s) under consideration;
- membership of and acceptance by the target community;
- gender equity appropriate to the context (considering affirmative action to preferentially select women to empower them and, where culturally relevant, to ensure acceptability of services by the population or target group);
- personal attributes, capacities, values, and life and professional experiences of the candidates (e.g. cognitive abilities, integrity, motivation,

interpersonal skills, demonstrated commitment to community service, and a public service ethos).

As with most of the recommendations, the strength of the recommendation is 'conditional'. (The Guideline does not explicitly define the term 'conditional', but the note for one of the Recommendations (3) says 'The recommendation was framed as a conditional one, recognizing both the importance of adapting it to national and local context and the moderate certainty and very limited scope of the underpinning evidence'.

Under 'Interpretation of the evidence and other considerations by the GDG (in relation to Recommendation 1), the Guideline notes the following:

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**Level of education.** The most appropriate level of primary or secondary education prior to CHW training may depend on the complexity of the tasks undertaken by CHWs. While a higher level of prior education may be associated with improved knowledge and performance, attrition (due to better and more diverse work opportunities) might be higher among more educated CHWs. A requirement for relatively higher levels of education may restrict excessively the pool of potential candidates, risks excluding women in particular in many contexts, and would be difficult to implement in contexts with low levels of educational attainment. The minimum level of education considered to be appropriate will depend on the tasks to be delivered, the context of the services and the training support available. Testing for certain competencies during selection (for example, literacy and numeracy) may be considered as an alternative approach

in contexts where employing strict education attainment requirements would imply restricting excessively the applicant pool, for women in particular.

**Membership of target community.** The GDG considered that membership of and acceptance by the target community (whether defined in geographical terms or in relation to population group, such as nomadic communities, people living with HIV, caste, religion or cultural beliefs) may represent an important criterion in the selection process.

**Age.** No evidence was found to justify age as a selection criterion (beyond adherence to the minimum legal working age). Age can be an important factor in some contexts, but it is not necessarily clear in which way it can or should be used: educating younger CHWs may theoretically contribute to a longer working lifespan, but at the same time there are reports of higher turnover among younger CHWs. Individual values and capacities gained

through previous life experience may be more important than age. The GDG considered that from an equity and rights-based perspective, the potential harms of discriminating based on age would probably outweigh potential benefits under most circumstances.

Age should therefore not be a restricting factor; personnel responsible for selection should prioritize other criteria, such as relevant life experience, acceptability, caring attitude, commitment and other relevant individual attributes.

Gender. No evidence was found supporting gender as a selection criterion. The GDG considered that from an equity and rights perspective, it is necessary to avoid unfair discrimination based on gender. Considering the existing gender inequities, particularly in low-resource settings,

the GDG noted the importance of adopting in the selection process criteria that would be instrumental in improving gender equity. Recruitment and selection procedures that maximize women's participation and promote women's empowerment should be encouraged. The GDG also recognized that in certain cultural contexts it is necessary for certain services - particularly reproductive, maternal, newborn and child health - to be rendered by female providers. The choice on the use of gender as a selection criterion under certain circumstances and for certain services should be made on the basis of the local sociocultural context and the specific role expected of the CHWs.

Marital status. Marital status is used as a selection criterion in some contexts. However, no evidence was found to support the use of marital status as a selection criterion. In contrast to other selection criteria, the GDG considered that there are no circumstances under which any theoretical (and unproven) benefits of the use of marital status can plausibly outweigh its negative implications. The use of this criterion therefore can limit the potential for recruitment of effective CHWs and could represent an unjustifiable discrimination and violate human and labour rights. With the aims to improve equity and the potential pool of effective CHWs, the GDG therefore adopted a strong recommendation against the use of marital status as a selection criterion.

--

We look forward to your comments on any of the above.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (54) Selection of CHWs for pre-service training (12)

12 June, 2019

Dear Sir,

You very correct as regard Nigeria experience. I happened to be one of the Community Health Practitioners in Nigeria. Community Health Officer (CHO) to be precise.

The training of CHO is taking place at University Teaching Hospitals leading to the award of Higher Diploma in Community health. Duration: 2 years. Candidate to the admitted for this training must be a CHEW with five years post qualification experience.

Other cadres are being trained at Colleges of Health Technology for duration of 2years for JCHEW and 3 years for CHEW

All Community health practitioners must be registered and licensed to practice by the Community Health practitioners Registration Board of Nigeria.

Community health practitioner in Nigeria, have both Clinical based and Community based Functions. In the community, we spend substantial part of time on home visit, contact tracing and house to house immunization.

We also supervise Traditional Birth Attendants in the Community.

We have a formidable professional association: National Association of Community Health Practitioners of Nigeria (NACHPN)

As the main primary health care service providers in Nigeria, our Association is opened and ready for collaboration with individuals, similar professional association in other countries, international organization and stakeholders etc, to better achieve our goal of health for all Nigerian.

I am very happy to be a Community Health worker.

Tijani, M.A  
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Community health: our Concerns

HIFA profile: Tijani Musibau Akande is Community Health Officer at the Ministry of Health, Ogun State, Nigeria. Professional interests: Primary Health Care and Community Health. [tjanimao AT gmail.com](mailto:tjanimao@gmail.com)

<https://hifaforums.org/?r6r2dkjq>

CHWs (55) Integration of Ayurveda and Homeopathy practitioners? (2)

12 June, 2019

Hi,

I had posted about integrating services of alternative health practitioners (Ayurveda and homeopathy) as CHW.

These are supporting statements.

80% of health care in India is private (pay from pocket). This is often provided by alternative practitioners as there is shortage of MBBS doctors in India. These doctors generally provide allopathic (modern medicine) treatment to patients despite their degree. So its a skilled workforce available.

For rural population and urban poor, these practitioners are the main providers of primary care. Their services are seen as value for money and are mainly symptomatic.

Preventive health care is segregated to government centers and somehow there is discord between private and government health services.

Private is quick, value for money, focused on symptomatic relief and patient satisfaction, whereas as government services are slow, generally free, but with less patient satisfaction.

It might be a good idea to integrate services of these private health practitioners as CHW so as to achieve integration of curative and preventive health goals and synthesis and cooperation between government and private health services. Unless these two start working hand in hand, it will be difficult to achieve our goals.

You may or may not post this in the forum, but I thought of expanding on the idea which had come off while reading the discussions on CHW.

Regards,

Narendra

HIFA profile: Narendra Javadekar is a physician and health economist with RESPIRE in India and has a professional interest in internal medicine, health economics, and public health. Email address: narenjavdekar AT yahoo.co.in

## CHWs (56) Reflections on CHW Discussion Week 1 (4) Fulltime CHWs and Part-time CH Volunteers

13 June, 2019

Hi Amelia,

This is an issue I personally find very interesting. The CHW Guidelines stress the importance of formalizing national CHW cadres, yet they also recognize the diversity of the workforce and the need to keep it diverse in many contexts. Some CHWs/volunteers may not want or need to work on a full time basis and may have special skills or characteristics that make them important to strengthening health care e.g. PLHIV [\*] peer educators, mentor mothers, or others. How do we best combine the need for full-time extensively trained and salaried community health workers, with part-time, specialized and incentivized (or non-incentivized) “volunteers?” Certainly

more evidence on team-based approaches to community-level care are needed and the logistical challenges of training and managing a diverse community workforce are presently being grappled with in many countries. I looked through CHW Central's resources but didn't find comparative analysis of country programs that focuses on their workforce structures or team-based approaches (FT CHW - PT CHW/Volunteer), but those interested might find the following resources useful:

Case studies of large-scale CHW programs by Perry et. al.  
2017. <https://www.chwcentral.org/case-studies-large-scale-community-health-wor...>

Factors enabling community health workers and volunteers to overcome sociocultural barriers to behaviour change: meta-synthesis using the concept of social capital. By Mohajer and Singh.  
2018. <https://www.chwcentral.org/sites/default/files/untitled.pdf>

Can a community health worker and a trained traditional birth attendant work as a team to deliver child health interventions in rural Zambia? By Yeboah-Antwi et. al.  
2014 [https://www.chwcentral.org/sites/default/files/CHW\\_TBA\\_Team\\_Zambia\\_2014.pdf](https://www.chwcentral.org/sites/default/files/CHW_TBA_Team_Zambia_2014.pdf)

Feel free to visit [www.CHWCentral.org](http://www.CHWCentral.org) to explore additional resources.  
Hope this useful! Becky

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HIFA profile: Rebecca Furth is Senior Technical Advisor at Initiatives Inc., USA. Professional interests: Human Resources for Health, Community Health Worker program strengthening, Organizational capacity building, Health systems strengthening, Culture and development. She is a member of the HIFA working group on CHWs. <http://www.hifa.org/support/members/rebecca-0>

[\*Note from HIFA moderator (Neil PW): PLHIV =People Living with HIV]

## CHWs (57) Integration of Ayurveda and Homeopathy practitioners? (3) Unqualified allopathic practitioners

13 June, 2019

Here is my humble take on this topic:

The problems with unqualified and under-qualified allopathic practitioners is misuse of medications leading to antibiotic, anti tubercular and anti-pain drug resistance. Also common use of injections and IV infusion equipment with low or no sterilization leads to spread of viral and bacterial infections.

What happened in Larkana district in Pakistan, where so many pediatric cases of HIV infection have been detected should be a lesson for India and other regional countries where medical practice is unregulated through so called health practitioners.

Thank You

Sincerely

Shabina

Dr. Shabina Hussain, MBBS, DPH, MPH  
Mount Lake Terrace  
WA 98043. USA

HIFA profile: Shabina Hussain is an independent global health consultant and is based in the USA. Professional interests: Maternal & Child Health, Family Planning, Reproductive & Sexual Health, women's rights, survival of girl child, poverty eradication, Prevention of Infectious diseases.  
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## CHWs (58) Reflections on CHW Discussion Week 1 (5) Geographical distribution of CHWs

13 June, 2019

Amelia thank you. [In response to Amelia Plant: "One clarifying question: out of all of these different cadre of CHP/CHO/CHEW/JCHEWs in Nigeria, which are based in the communities they are from?..." <http://www.hifa.org/dgroups-rss/chws-51-reflections-chw-discussion-week-1-3> ]

In Nigeria, the schools / Colleges of Technology are typically based in the state capital. On graduation the CHP is employed by the ministry of health (or more recently the new creations called 'state primary health care development agency' to a primary health centre) and posted to PHCs across the state more than 80% located in rural parts of the state.

I may clarify further by adding that the JCHEW and CHEW are the ones trained in the colleges, and that the CHO cadre are actually trained for Diploma certification in the university near the college of health technology. The CHO is also employed by the ministry of health and posted to PHC, some of whom will be based in the local government headquarter as the PHC Coordinator for the Local Government, coordinating all his/her colleagues activities and reporting to the ministry of health headquarters.

Furthermore the JCHEWs are specifically the cadre that mandatorily run the home visits and report to the CHEWs and CHOs in the PHC nearest to them.

By coincidence most CHPs are from the state where they are trained and located, but their posting does not specify that they be posted to their village of origin. Except in a few cases like in Cross River State where as the Commissioner for Health, I was introduced to and I engaged a Non Governmental Organisation called Tulsu Chandrai to come to the state in 2006: I had visited their operations in another state (Kaduna state) and was very impressed by their methodology - Tulsu Chandrai PHC model was to work with a community who nominate their indigene (s) and are screened by Tulsu for training in the college in that state, and on completion of training return to their village of origin to serve as CHW.

I was impressed because it helped to solve the problems that arose from posting CHP to rural areas that they are not from and are not familiar with, and which mostly do not have any recreation facility of school or market or road, etc. The indigene usually is already accustomed to living in their village and are also can speak the language / dialect and know the customs, etc.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a

pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

## CHWs (59) Selection of CHWs for pre-service training (13) National Association of Community Health Practitioners of Nigeria

13 June, 2019

It is nice to read the greater details that Tijani Akande posted on community Health Practitioners in Nigeria. Let me add that the National Association of Community Health Practitioners of Nigeria (NACHPN) at its Annual General meeting in Calabar, Nigeria gave me an Award of Appreciation for the contribution of my team and I to primary health care in Nigeria. I was pleasantly surprised that such a powerful association was in the know of our efforts to strengthen health care in Nigeria beginning from the primary health care tier.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

## CHWs (60) Resources for Community Engagement

13 June, 2019

The latest Compass Trending Topic covers resources for social and behavior change in the area of community engagement - we invite you to review the page and contribute your own resources to this list. <https://is.gd/xaXnqY>

Best regards,

Susan Leibtag

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[www.thecompassforsbc.org](http://www.thecompassforsbc.org)  
[www.springboardforsbc.org](http://www.springboardforsbc.org)  
[www.breakthroughactionandresearch.org](http://www.breakthroughactionandresearch.org)

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## CHWs (61) Selection of CHWs for pre-service training (13) Do you have practical experience of CHW selection?

13 June, 2019

Dear HIFA colleagues,

I would like to invite comment and discussion on the Implementation considerations for Recommendation 1: Selection of CHWs for pre-service training. In particular I invite HIFA members with real-world experience of selection of CHWs to share your experience (see my comment below).

## CHWs (62) Ebola in DR Congo (3)

14 June, 2019

Thanks Joseph for the updates and highlights on ebola

Actually the Ebola situation in Congo and the borders of Uganda as observed is an example of why we need to embrace the CHW who can educate communities on some of these deadly diseases. Cause am told the people still think that Ebola is witchcraft as it was with HIV in Uganda when it had just been detected. CHWs can demystify myths better if well trained. More so, knowing that we don't have enough medical people to do facility work and community work.

That's what I think

Happy

HIFA profile: Happy Annet Walusaga is a community linkages coordinator at Makerere Joint AIDS Program in Uganda. Professional interests: breaking down medical concepts to understandable units by the local community members in my region, hence empowering the community with knowledge to prevent HIV transmission, treatment and care, fight stigma, understand and promote as well as preventing and managing other diseases of public health importance in an all-inclusive community. email address: happyannetw AT yahoo.com

## CHWs (63) Do you have practical experience of CHW selection? (2)

14 June, 2019

Dear All,

To Neil's question, Do any HIFA members have experience of selecting CHWs for pre-service training?, I say the following:

As Chief Executive of a state ministry of Health in Nigeria that upgraded a school of Health Technology to a College of Health Technology in our overall plan to strengthen the health system with the anchor as the primary health care tier including expanding the system to a multi sectoral and multi disciplinary PHC, I was involved in preparing designing, drafting and implementing the plan. We head-hunted the leadership of the college looking for persons health professionals with PHC experience and expanding the curriculum of the college once it received legal Act from the State House of Assembly. Then we looked around the country for models that we

could adopt for the state: I spent one working week with a non governmental NGO called Tulsi Chandrai Foundation (TCF) in another state (Kaduna state) in the Northern part of the country and conducted daily study tours with the NGO staff as they visited CHWs in their stations including doing Home visits. I was impressed so that on returning to my base in Calabar, I sent a team of CHW and nurses/midwives to do what I had just done in Kaduna state.

As I shared in a previous post in this discussion, the Tulsi Chandrai Foundation model was very impressive because it engages a community, encourages the community to nominate its youths to be trained as CHWs and to donate a building where the CHW will work from and live in one of the rooms in the building after training, TCF and government equip the facility and pay the CHW and other staff. The advantages are numerous: 'the selection of an eligible CHW from within the community may also facilitate the delivery of more linguistically and culturally appropriate services'. The familiarity with the environment and acquaintance with the community eases the implementation of interventions, builds trust that aids compliance with several messages like immunisation, reproduction health advice, breast feeding, medication use, sanitation and many others. If there was any problem at all with this model, it may be that because the older members of the community know the background of the CHW, coming from their village, they may continue to under-rate their professional status and advice, continuing to see them as 'children' not grown up and trained professionals. To overcome this challenge the CHWs are trained to carry themselves as skilled professionals with dignity and respect for elders. The positive outcome of those who follow their advice usually brings the doubters around with time. The CHW are also trained to avoid bias, discrimination and nepotism when carrying out their roles in their community of origin.

I should add that while some of the pre-training selection criteria and attributes listed in the WHO guideline are easier to implement even in the TCF model (even though we did not ourselves specifically use them in that way in Calabar) including 'a demonstrated commitment and attitude to community service', 'being proactive, cooperative and adaptable', some other criteria may be more difficult to implement in many LMICs such as 'leadership skills', 'prior relevant work experience', and 'relevant cognitive skills'. And even other criteria may be almost impossible to implement at the pre service selection stage, and I rather think that they should await the post training / recruitment stage such as 'the capacity and willingness to progressively develop an understanding of the local context and community'. The shortage of human resource in health who would comprise the selection team is the main reason why the selection criteria need to be a bit less stringent and contextual, if the recruitment is to remain attractive for applicants and workable for the selectors.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group and the HIFGA working group on Community Health Workers: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

## CHWs (64) Ebola in DR Congo (4) CHWs and health education

14 June, 2019

Happy, thank you for your suggestion on the need to engage more CHW to fill the gaps in the field that have arisen due to the shortage of human resources in health (HRH) not only in DR Congo but across the globe.

The problem is more acute in LMICs especially Africa where as you rightly say, 'the people still think that Ebola is witchcraft as it was with HIV in Uganda when it had just been detected'. It is astonishing to see how long this witchcraft myths has persisted in LMICs particularly in Africa, in spite of the all-time high registration in education in the continent. It seems that the more people are educated the more health myths persist. Surely, it illustrates how weak the health systems are, that they fail to eliminate such myths. How health education is not given the right priority in country after country. Sadly, it has a direct correlation with the failure to bridge the gap in the health worker: population ratio, as long as the shortage of HRH persists.

I agree with Happy, we all need to use every tool to fight damaging health and health-related myths wherever they exist, including engaging CHWs and training them well.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group and the HIFGA working group on Community Health Workers: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

## CHWs (65) Role of CHWs in disability and rehabilitation (7) WHO Fact Sheet: Rehabilitation

14 June, 2019

WHO has this week published a new Fact Sheet on Rehabilitation. Read online here: <https://www.who.int/news-room/fact-sheets/detail/rehabilitation>

13 June 2019

### KEY FACTS

- Rehabilitation is a set of interventions needed when a person is experiencing or is likely to experience limitations in everyday functioning due to ageing or a health condition, including chronic diseases or disorders, injuries or traumas. Examples of limitations in functioning are difficulties in thinking, seeing, hearing, communicating, moving around, having relationships or keeping a job.
- Rehabilitation is an essential component of universal health coverage along with promotion, prevention, treatment and palliation.
- There is an increasing need for rehabilitation worldwide associated with

changing health and demographic trends of increasing prevalence of noncommunicable diseases and population ageing. The proportion of individuals aged over 60 is predicted to double by 2050 and there has been an 18% increase in the prevalence of noncommunicable diseases in the last 10 years.

15% of all years lived with disability (YLDs) are caused by health conditions associated with severe levels of disability. Rehabilitation is a fundamental health intervention for people living with these conditions.

- At present the subsequent need for rehabilitation is largely unmet. For example, in many low- and middle-income countries, there is a lack of trained professionals to provide rehabilitation services, with less than 10 skilled practitioners per 1 million population. [...]

Comment (NPW): The fact sheet talks about unmet need and how rehabilitation can be better integrated in health systems, but does not specifically mention the role of CHWs in rehabilitation.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (66) CHWs and non-communicable disease management in humanitarian settings

15 June, 2019

Dear all,

I am an epidemiologist working on disease control in emergencies.

I am looking for any descriptive reports, training materials, and evaluation reports on CHW programmes focusing on community-based NCD control. I am

particularly interested in humanitarian settings and fragile states, but also programmes in LMICs. Some examples (Mexico:

<https://gh.bmj.com/content/3/1/e000566>,

Lebanon for Syrian refugees:

<http://www.ghspjournal.org/content/5/3/495>).

Along with the University of Southern California and the Jordan University of Science and Technology, at International Rescue Committee (IRC), we are conducting operational research to improve the community health volunteer program and evaluate adherence for high-needs NCD patients among the Syrian population resident in northern Jordan. We are looking at new models for community health to incorporate into IRC's long-running community health program.

Information on our study:

<https://www.elrha.org/project/optimizing-a-community-based-model-for-cas...>

We are looking for more insights and evidence from CHW programmes that address diabetes and hypertension in the community. We are trying to incorporate lessons learned from other programs -- as there are so few, and next to none that are published.

Thank you in advance for considering my request on your time and sharing your insights! Please feel free to get in touch.

Ruwan

HIFA profile: Ruwan Ratnayake is a epidemiologist and PhD candidate with LSHTM, was previously the epidemiologist for the International Rescue Committee and others, and is from Canada. He is interested in CHWs and NCDs and CHWs and surveillance, both within the context of humanitarian crises and large-scale epidemics. Email address: ruwan.epi AT gmail.com

## CHWs (67) Length of pre-service training for CHWs

16 June, 2019

Dear HIFA colleagues,

Thank you for your contributions during weeks 1 and 2. You can review previous contributions on our RSS feed here: <http://www.hifa.org/rss-feeds/17>

This week we are looking at Recommendations 2, 3 and 4 (length of pre-service training, competency domains and modalities).

We invite you to consider Recommendation 2 (length of pre-service training). The policy question that is addressed by the Guideline is: "For CHWs receiving pre-service training, should the duration of training be shorter versus longer?"

## RECOMMENDATION 2:

WHO suggests using the following criteria for determining the length of pre-service training for CHWs:

- scope of work, and anticipated responsibilities and role;
- competencies required to ensure high-quality service delivery;
- pre-existing knowledge and skills (whether acquired through prior training or relevant experience);
- social, economic and geographical circumstances of trainees;
- institutional capacity to provide the training;
- expected conditions of practice.

Certainty of the evidence - low. Strength of the recommendation - conditional.

As a personal comment, this recommendation is (like the majority of recommendations) 'conditional', ie context-dependent. As the Guideline states, 'The most appropriate duration of training should be established in a national or subnational context on the basis of local needs and circumstances.'

The Guideline notes that: 'Currently the length of CHW training is not standardized, with its duration ranging from a few hours to several years'. It does not propose any minimum or maximum lengths of pre-service training, with the implication that there may be contexts in which a few hours or several years, or anything in between, may be appropriate.

Interestingly and perhaps surprisingly, the 'systematic review of reviews found that... training duration had no consistent effect on the effectiveness of the intervention'. Perhaps it is quality of training that matters, as well as other factors such as supportive supervision and the existence or otherwise of in-service training?

Have you received training to become a community health worker? We look forward to learn from your experience. How long is the training in your country? is this too short, too long, or about right?

Do you have experience in training CHWs? We look forward to hear your views on length of pre-service training.

As a reminder: We welcome any messages on any aspect of CHWs at any time - please send your contribution by email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (68) Do you have practical experience of CHW selection? (3)

16 June, 2019

Dear Colleagues: 15 June, 2019

Thank you, Sr Ana for that practical advice on CHW recruitment. I concur wholeheartedly with your points.

My only (and perhaps minor) dissent remains the use of the word professional. It seems to me that the word paraprofessional is useful.

When it comes to medical or even health knowledge, educational degrees should count, in the sense that they confer a science based data base which cannot be available to the CHW. To establish and maintain quality of care, there should be an hierarchy based on the science of health. I would however ascribe superior knowledge of the community to the CHW recruited from that community; hence doctors, nurses, midwives and other health specialists should understand and accept the CHW's superior understanding of community politics, belief systems, sensitivities, "reference figures" and past history all of which are relevant to the design of primary care, for that community. For that kind of knowledge, a reverse hierarchy is appropriate!

Respectfully,

Nicholas Cunningham MD Dr P.H.

HIFA profile: Nicholas Cunningham is Emeritus Professor of Clinical Pediatrics & Clinical Public Health at Columbia University, New York, USA. He is interested in International Primary Maternal and Child Health Care, community owned, professionally overseen, and supported by \$/power interests, incorporating integrated cure/prevention, midwifery/child care, child saving/child spacing, nutrition/infection, health/education (especially female), monitored but not evaluated for at least 5-10 years, based on methods pioneered by David Morley at Imesi (Nigeria) and by the Aroles at the Jamkhed villages in Maharashtra State in India. Totatot AT aol.com

## CHWs (69) What do community health workers want?

16 June, 2019

Below are the citation and abstract of a new paper in BMJ GlobalHealth, and a comment from me.

CITATION: Abdel-All M, Angell B, Jan S, et al What do community health workers want? Findings of a discrete choice experiment among Accredited Social Health Activists (ASHAs) in India BMJ Global Health 2019;4:e001509.

<http://dx.doi.org/10.1136/bmjgh-2019-001509>

### ABSTRACT

Introduction: A number of factors contribute to the performance and motivation of India's Accredited Social Health Activists (ASHAs). This study aims to identify the key motivational factors (and their relative importance) that may help retain ASHAs in service.

**Methods:** A discrete choice experiment (DCE) survey presented ASHAs with eight unlabelled choice sets, each describing two hypothetical jobs that varied based on five attributes, specifically salary, workload, travel allowance, supervision and other job benefits. Multinomial logit and latent class (LC) models were used to estimate stated preferences for the attributes.

**Result:** We invited 318 ASHAs from 53 primary health centres of Guntur, a district in south India. The DCE was completed by 299 ASHAs using Android tablets. ASHAs were found to exhibit a strong preference for jobs that incorporated training leading to promotion, a fixed salary and free family healthcare. ASHAs were willing to sacrifice 2530 Indian rupee (INR) from their monthly salary, for a job offering training leading to promotion opportunity and 879 INR for a free family health-check. However, there was significant heterogeneity in preferences across the respondents. The LC model identified three distinct groups (comprising 51%, 35% and 13% of our cohort, respectively). Group 1 and 2 preferences were dominated by the training and salary attributes with group 2 having higher preference for free family health-check while group 3 preferences were dominated by workload. Relative to group 3, ASHAs in groups 1 and 2 were more likely to have a higher level of education and less likely to be the main income earners for their families.

**Conclusion:** ASHAs are motivated by both non-financial and financial factors and there is significant heterogeneity between workers. Policy decisions aimed at overcoming workforce attrition should target those areas that are most valued by ASHAs to maximise the value of investments into these workers.

**COMMENT (NPW):** ASHAs (community health workers in India) 'are motivated by both non-financial and financial factors'. Interestingly, they were found 'to exhibit a strong preference for jobs that incorporated training leading to promotion, a fixed salary and free family healthcare'.

Currently the career progression opportunities for CHWs worldwide are limited. Just as with other health workers, it make sense to have a career ladder with the possibility of further training for 'higher cadres'. Personally, I find the systematic promotion of career pathways quite exciting - this has the potential not only to be a motivating factor for selection, certification, and service, but also to strengthen links between CHWs and other members of the primary healthcare team. Indeed, a health professional who originally trained as a CHW and who has then gone on to further training will have exceptional skills and qualities that are less likely to be seen in colleagues who have not had that experience.

All this is reflected in Recommendation 9 of the CHW Guideline: 'a career ladder should be offered to practising CHWs'.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (70) Do you have practical experience of CHW selection? (4)

16 June, 2019

Prof Cunningham thank you for your posting.

I used 'professional' in the widest sense not restricting it to any strict definition. I am sure that even the CHW would accept that they are paraprofessional. In that sense you are right. Who knows when their scope, role, curriculum and job description rise they may like other cadres in recent memory demand to be called professionals.

But I think that we should not compartmentalise the cadres into such different folios, for that risks failure of attempts at effective multi disciplinary team working. In a recent pilot of a tool that literally binds all cadres in primary health care to work together so long as there is clear delineation of roles and responsibilities: the highly successful PACK Nigeria Programme pilot in 2017 brought CHPs, nurses, midwives and doctors working harmoniously (rare in Nigeria) by being informed of their limits based on their curriculum and training, and referring patients to the next higher cadre in a timely and safe manner.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group and the HIFGA working group on Community Health Workers: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

## CHWs (71) Length of pre-service training for CHWs (2)

17 June, 2019

I reproduce in full Recommendation 2; Implementation considerations for this Recommendation; examples from Ethiopia, Mozambique and Pakistan; and a Comment from me below.

### RECOMMENDATION 2

WHO suggests using the following criteria for determining the length of pre-service training for CHWs:

- scope of work, and anticipated responsibilities and role;
- competencies required to ensure high-quality service delivery;
- pre-existing knowledge and skills (whether acquired through prior training or relevant experience);
- social, economic and geographical circumstances of trainees;
- institutional capacity to provide the training;
- expected conditions of practice.

### IMPLEMENTATION CONSIDERATIONS

The most appropriate duration of training should be established in a national or subnational context on the basis of local needs and circumstances, including the need to maintain a clear delineation of roles and responsibilities with other types of health workers working in the context of integrated primary health care teams. Training duration should be feasible, acceptable and affordable in the context

of a specific jurisdiction, while long enough to ensure that the desired level of competencies and expertise is achieved.

As these vary substantially based on the role that CHWs play, it is expected that CHWs with a polyvalent role and working on a full-time or regular basis (that is, those delivering more complex interventions or a wide range of primary health care services) would require longer training than those providing a single focused service on a more occasional basis. Table 3 [see below] provides selected examples of pre-service education that is considered by national policy-makers to be of appropriate duration (typically several months) in relation to the learning objectives of CHWs with a polyvalent role. CHWs with a more limited set of responsibilities have a shorter pre-service education (for example, 23 days for accredited social health activists in India) (67).

In determining the most appropriate length of training, the role and importance of cross-cutting skills (for example, patient communication, community engagement) should be factored in, avoiding too narrow a focus on the transfer of only diagnostic and clinical skills.

The length of the training might also need to reflect the need for and appropriateness of phased training based on different modules delivered after some intervals of practice. Besides length of training, the adoption of relevant adult learning practices and the appropriate design of the training programme may be equally or even more important in determining the effectiveness of pre-service education. The education approach should be seen holistically as part of a broader set of strategies that include also appropriate quality, frequency and relevance of supportive supervision and opportunities for periodic retraining and continuous professional development.

### TABLE 3: DURATION OF TRAINING FOR CHWS WITH A POLYVALENT ROLE

Ethiopia - Community health extension workers - Promotive and preventive activities; diagnosis, basic treatment and referral services for most prevalent conditions; essential behaviour change communication; administrative duties, including health record keeping, organization of services at community level, management of essential medical supplies

12 months (30% theoretical, 70% practical)

Mozambique - Agentes polivalentes elementares - Illness prevention and health promotion activities; nutritional and vaccination surveillance; diagnosis, treatment and referral of common conditions; family planning, pregnancy and newborn follow-up; HIV and TB adherence; health data reporting

4 months (approximately 50% theoretical, 50% practical)

Pakistan - Lady health workers Provide primary health care services, with special emphasis on reproductive, maternal, newborn, child and adolescent health, and organize communities by developing women's groups and health committees in the catchment areas

15 months (20% theoretical, 80% practical)

COMMENT (NPW): The country examples in the Table appear to be especially useful for South-South sharing of experience. This begs the question of building a more complete data-set of the duration of training of CHWs across all LMICs, together with the roles of trained CHWs. There will likely be variation within countries, and between different types of organisation. Another issue is the extent to which CHWs are supervised (or otherwise) in the early months following training. We look forward also to learn more about the methods of 'theoretical' and 'practical' training... Much to share!

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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## CHWs (72) Reflections on CHW Discussion Week 2

17 June, 2019

Greetings!

As a HIFA CHW working group member, I will post some brief reflections after each week, in hopes that discussion will continue to be galvanized. I invite my colleagues, both in and out of the working group, to do the same.

On the 10th, Neil Pakenham-Walsh noted, regarding CHW selection criteria, "I suspect there may be substantial variation within countries, especially perhaps between government-, NGO- and FBO-led (faith-based organisation) programmes?"

The same day, Narendra Javadekar informed us that, "There are many BAMS (Ayurveda) and BHMS (Homeopath) doctors in rural India doing private practice. Can we integrate them to such services?"

Setting aside the specific questions about homeopathic doctors and focusing on the private sector as a whole, there is great opportunity for linkages with the public sector. For instance, Uganda has government-trained and sponsored village health teams with community health workers. I recently had a conversation with some colleagues at Healthy Entrepreneurs (<https://www.healthyentrepreneurs.nl/>), an organization that trains existing VHT/CHWs to be entrepreneurs, selling a basket of health products and services.

There is certainly a debate about the use of CHWs in the public vs. private sector -- should they charge for their services, be part of a nationalized free health care system, somewhere in between, or both. I am sure we will delve into these questions in further discussions. That aside, I found the Healthy Entrepreneurs example quite instructive -- taking existing CHWs and giving them more training and more avenues to earn money. This needs to be done carefully, of course, and may not work in some contexts in which CHWs are working full time and earning salaries through the health system. But it has great potential, and underscores the need for clear and consistent pre-service training guidelines so that organizations know how to build off of each other, and how to use existing resources.

Thank you,

Amelia

HIFA profile: Amelia Plant is the Portfolio & Impact Manager at Preston-Werner Ventures, a San Francisco-based foundation looking to create

scalable impact at the intersection of climate change and social justice. Amelia specializes in sexual reproductive health and rights, focusing on family planning information & access. She is currently based in Cairo, Egypt. She is a member of the HIFA working group on Family Planning and the HIFA wg on Community Health Workers.

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## CHWs (73) Length of pre-service training for CHWs (3) Training traditional birth attendants in Nigeria (10)

17 June, 2019

Tijani, thank you for sharing your experience of being a community health worker [<http://www.hifa.org/dgroups-rss/chws-54-selection-chws-pre-service-train...>]. It is so instructive, and I sincerely hope we hear from other CHWs as well.

You mentioned the various training durations for the cadres of CHWs in Nigeria, mostly varying from 2-3 years. Most non-governmental organizations seem to train "their" CHWs for anywhere from a week to a few months, with additional in-service training components. This practice is underscored in the WHO guideline as well, which stated that "training duration had no consistent effect on the effectiveness of the intervention."

Do you endorse the length of training required in Nigeria? What exactly is covered? Although WHO found no effect on "effectiveness" from training duration, I wonder if a longer training better prepares a CHW to ascend the career ladder in places like Nigeria, where those options are available.

You also mentioned that you supervise traditional birth attendants. How does that relationship work at the village level, and within the overall health system?

Again, thank you for your valuable contribution.

Amelia

HIFA profile: Amelia Plant is the Portfolio & Impact Manager at Preston-Werner Ventures, a San Francisco-based foundation looking to create scalable impact at the intersection of climate change and social justice.

Amelia specializes in sexual reproductive health and rights, focusing on family planning information & access. She is currently based in Cairo, Egypt. She is a member of the HIFA working group on Family Planning and the HIFA wg on Community Health Workers.

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## CHWs (74) Companion Care program run by medical students, USA

17 June, 2019

Dear community,

Here a really good case study on a CHW program run by medical students:

<http://chwcentral.org/blog/companion-care-creating-and-maintaining-conne...>

Regards,

Héctor Carrasco

HIFA profile: Hector Carrasco\* is a medical doctor and DrPH Candidate at Harvard T.H. Chan School of Public Health. he.carrasco03 AT gmail

## CHWs (75) Length of pre-service training for CHWS (4)

17 June, 2019

In Nigeria the CHW / CHP are trained to play 'polyvalent' role in the primary health care tier of the health system.

The Nigeria National Task Shifting and Sharing Policy 2014 to address the challenges regarding HRH shortage, mal-distribution and clinical competence. The policy was designed to accelerate efforts to meet the MDGs but is now directed at meeting Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

Human Resource in Health (HRH) of Nigeria is an issue of great concern because It is far below the absolute minimum requirement of 2.28 per 1,000 mentioned in the 2006 World Health Report.

The most recent information on numbers and density of health workers is available in the “Nigeria Health Workers Profile published in 2013. There are huge discrepancies between total numbers in the Registries kept by the regulatory councils and those deemed to be “in good standing”, the latter is far more likely, reflecting a the weakness of the councils and the numbers of thevarious cadres in active practise in Nigeria, with a population of about 193 million..

Nationally, as of December 2012, 20,284 medical doctors were in good standing, and the density per 100,000 populations, ranged from 50.5 in Federal Capital Territory to 1.9 in Yobe State, and the 8.9 medical doctors per 100,000 in Sokoto state.

The numberof Nurses and Midwives who are in good standing was not available from the Nursing and Midwifery Council (NMC). But Information from the States revealed densities of nurses and midwives per 100,000 population ranged from 5.9 in Zamfara State to as high as 96.5 in Imo State, and 24.7 in Niger State.(Note that Yobe state is in Boko Haram insurgency area since 2009).

According to the National Primary Health Care Development Agency (NPHCDA) for the Midwives Service Scheme (MSS) in2009 there were 36,737 CHWs and 5,604 skilled practitioner (doctors, nurses and midwives). The breakdown of CHW shows that 28% were Health Assistants, 11% Junior CHEWs, 27% CHEWs, and 4% CHOs. Nurses and midwives less than 8%. Doctors were even fewer.

For service delivery, 90% of deliveries at the PHCs were conducted by CHEWs. An assessment of the knowledge and skills of the CHEWs showed that 70.3% of them had some basic theoretical knowledge of midwifery, but only 31% could correctly assess foetal well-being. 56% knew about the routine tests to be done during ANC, indicating gaps in their level of skills.

To make things worse, there is massive external migration of medical doctors and nurses (Brain Drain) that reached its peak between 2002 and 2007, reduced slightly in 2012 but again on the increase since 2015. The loss to brain drain represents about 38% of the annual training output of medical doctors in 2012, a little over 3000 per annum. The difference of the number of doctors in the register and the number in good standing was attributed to backlogs with the updating of theregistries, due to frequent dissolution of thecouncil which affects its effectiveness.

Therefore, the duration and curriculum for training CHWs focuses on key priority areas such as Family and Reproductive Health, Maternal and Child Health services (RMNCH), as well as HIV, TB, Malaria, other Communicable

diseases and neglected tropical diseases, and Non-Communicable Diseases. Some of the details include:

Family Health: Ante-natal care, delivery and new-born care, post-natal care, Family planning, Child health - integrated Management of Childhood Illnesses (IMCI), growth monitoring and essential nutrition, immunization, Adolescent reproductive health; Communicable diseases: Tuberculosis (TB) and leprosy, HIV/AIDS and sexually transmitted infections, Epidemic diseases (including malaria surveillance), rabies; Basic curative care: Treatment of major minor and chronic conditions; Hygiene and Water-borne diseases; environmental health; Health education: Health education and communication; etc.

In Nigeria, therefore, the CHW training curriculum and duration is designed to produce CHW capable of running the PHCs, with Task shifting implementation. The curriculum is focussed mainly on community diagnosis and treatment of minor ailment and diseases, assisting mid-level health workers in providing care at the clinics and community outreach. The Junior community health extension workers (JCHEW). They receive about two years training in the school/college of Health Technology than the next higher cadre, the CHEWs and have a smaller scope of practice. JCHEWs spend 90% of their work time in the communities and 10% in the health facility. Currently, PHCs are typically headed by community health extension workers (CHEWs). They are trained schools/college of Health Technology for 2-3 years and qualify with a diploma in community health care. They spend 60% of their time at the health facility and 40% in the community. JCHEWs are supervised by CHEWs. Community health officers (CHOs) receive initial training same as CHEWs but also add an additional year of training at a Teaching Hospital. CHOs are also based at the primary health care facility, provide a range of services and supervise CHEWs and JCHEWs.

Joseph Ana

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National Implementing Organisation: 12-Pillar Clinical Governance

National Implementing Organisation: PAK Nigeria Programme for PHC

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## CHWs (76) CHWs and non-communicable disease management in humanitarian settings (2) CHW Central

17 June, 2019

Hi Ruwan,

CHW Central has over 1000 resources on CHWs and CHW programs, which might provide some of what you're looking for. I did a quick search on NCDs on our resources database and came up with over 30 articles. You might find others searching diabetes or hypertension. Visit CHW Central <https://www.chwcentral.org/> to find more. You also might be interested in the feature on CHWs in occupied Palestine recently published in the CHWs and health equity feature series; click here: <https://www.chwcentral.org/blog/community-health-work-under-occupation-t...>

I hope this helps. If you don't find what you're looking for, feel free to contact me directly at [rfurth@initiativesinc.com](mailto:rfurth@initiativesinc.com). I would also be interested in learning more about your project. We're always looking for resources and for new features for CHW Central; let me know if you might be interested in submitting a feature once your operations research is underway.

Best regards,

Becky  
Technical Manager CHWCentral

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HIFA profile: Rebecca Furth is a public health specialist and cultural anthropologist. She is a Senior Technical Advisor at Initiatives Inc., USA and Technical Manager for [www.CHWCentral.org](http://www.CHWCentral.org). Her professional interests include human resources for health, community health worker program strengthening, organizational development, health systems strengthening, and culture and development. She is a member of the HIFA working group on CHWs. <http://www.hifa.org/support/members/rebecca-0> rfurth AT initiativesinc.com

## CHWs (77) Resources and CoPs for CHW programming

17 June, 2019

Dear HIFA Community,

Thank you for the enriching discussion on CHWs. I find it especially interesting as we think about CHWs in the context of primary health care and universal health coverage. I wanted to highlight a few key resources that might be useful with respect to CHWs for Family Planning and Reproductive Health Services.

The first is an Evidence Brief highlighting CHWs as a High Impact Practice for FP services [<https://www.fphighimpactpractices.org/briefs/community-health-workers/>]. The brief outlines the evidence for integrating CHWs into the health system to provide a range of contraceptive methods. The brief is an important tool that can be used to help advocate for CHWs to provide a wider range of methods including injectables or as a reference guide that outlines the body of evidence and research. This resource is available in French, Spanish and Portuguese as well.

The second resource is the Family Planning Training Resource Package a useful tool when designing training module for various service providers including CHWs [<https://www.fptraining.org/>]. The tool is organized by contraceptive method and includes resources for ice breakers, facilitator notes, role plays, and games to reinforce training. All materials are also available in French.

Finally, the WHO task sharing guidelines to optimize health worker roles for maternal and newborn health provide a comprehensive look at WHO recommendations for addressing global health worker shortages [[https://www.who.int/reproductivehealth/publications/maternal\\_perinatal\\_h...](https://www.who.int/reproductivehealth/publications/maternal_perinatal_h...)]. The Guideline is offered in an interactive format [<https://optimizemnh.org/>] that outlines the ranges of services WHO recommends for various health workers. A summary specific for family planning has also been developed and can be found on the WHO website

here [<https://apps.who.int/iris/bitstream/handle/10665/259633/WHO-RHR-17.20-en...>].

It seems like there are number of online Communities of Practice tackling this important issue which is great! Of interest is CHW Central [<https://www.chwcentral.org/who-hsg-hifa-collaboration-empowering-communi...>], a global resource for and about Community Health Workers and the CHW CoP through Collectivity [<http://blog.thecollectivity.org/2018/02/20/introducing-the-community-hea...>].

Nandita Thatte, IBP Initiative

Nandita Thatte, DrPH  
Implementing Best Practices (IBP) Initiative  
Department of Reproductive Health and Research  
World Health Organization  
Geneva, Switzerland  
Email: [thatten@who.int](mailto:thatten@who.int)

[www.who.int/reproductivehealth](http://www.who.int/reproductivehealth)

HIFA profile: Nandita Thatte is a Technical Officer at the World Health Organization, Geneva, Switzerland. She is a member of the HIFA working group on Family Planning.

[www.hifa.org/projects/family-planning](http://www.hifa.org/projects/family-planning) [www.hifa.org/support/members/nandita](http://www.hifa.org/support/members/nandita)

## CHWs (78) Competencies in curriculum for pre-service training

18 June, 2019

Dear HIFA colleagues,

Recommendation 3 of the Guideline 'suggests including the following competency domains for the curriculum for pre-service training of CHWs, if their expected role includes such functions'. How does this Recommendation relate to current practice in your country/experience? Is it implementable in your country/experience?

### RECOMMENDATION 3

WHO suggests including the following competency domains for the

curriculum for pre-service training of CHWs, if their expected role includes such functions.

Core:

- promotive and preventive services, identification of family health and social needs and risk;
- integration within the wider health care system in relation to the range of tasks to be performed in accordance with CHW role, including referral, collaborative relation with other health workers in primary care teams, patient

tracing, community disease surveillance, monitoring, and data collection, analysis and use;

- social and environmental determinants of health;
- providing psychosocial support;
- interpersonal skills related to confidentiality, communication, community engagement and mobilization;
- personal safety.

Additional:

- diagnostic, treatment and care in alignment with expected role(s) and applicable regulations on scope of practice.

Certainty of the evidence - moderate. Strength of the recommendation - conditional.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global

community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (79) Companion Care program run by medical students, USA (2)

18 June, 2019

Dear HIFA,

I am puzzled and concerned by this contribution. The Companion Care Program reports 53,000 homeless in a population of LA County of only 10.6 million. That is 1 in 200 of the LA County defined as homeless. The Court Statistics referred to by the Companion Care Program give 39,000 of the 53,000 as unsheltered, that suggests that 1 in 271 of the total population sleeping rough. The other 14,000 were sheltered.

The UK population is about 65 million, we have less than 5000 rough sleepers in the UK but 320,000 defined as homeless. That is 1 in 203 defined as homeless but only 1 in 13.000 is a rough sleeper (unsheltered).

These are rather shocking statistics for LA County even given the better climate than the UK. Does the whole US have such a large 'unsheltered' population with all the associated health care access concerns?

best wishes,

Alison Nicholls RN

UK Advanced Nurse Practitioner

HIFA profile: Alison Nicholls works at Trinity College, Oxford, UK.

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## CHWs (80) Competencies in curriculum for pre-service training (2)

18 June, 2019

Dear HIFA colleagues,

On behalf of the HIFA CHW working group, I would like to share the following questions that relate to our discussion this week (please feel free to comment on any of these questions):

1. Is there an official scope of work for CHWs in your context? If so, does pre-service training align to this scope of work?
2. What CHW competencies are required to ensure high-quality service delivery in your setting?
3. Is there pre-service training for CHWs in your context? If so, how is the pre-service training presented? Does the pre-service training align with the required competencies?
4. Is the pre-service training curriculated? If so, how has the curriculum been compiled? Is the curriculum credit-bearing and/or aligned to a qualifications framework?
5. What institutions have the capacity to provide training? Are trainees able to access the institution/s providing training (especially in terms of social, economic, and geographical realities)?
6. Is prior learning recognised in pre-service training in your context? If so, how is the recognition of prior learning (RPL) facilitated?
7. What are the conditions of practice for CHWs in your setting? Is the CHW pre-service training aligned to these conditions?

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (81) Selection of CHWs for pre-service training (15) Reflections on CHW Discussion week 2

18 June, 2019

Dear All,

There are a few points I would like to add today, in response to Neil's observation that there may be substantial variations within countries also when it comes to CHW selection criteria, competency domains, contexts and conditions of practice and more.

7.1.5 section of WHO guidelines are meant to optimize the CHW's work if implementation conditions are ideal. In reality, however, it is not always possible to select people with the perfect attributes at the pre-service stage. My experience is that the training post-recruitment stage helps them become multi-skilled and makes them the much valued front line workers we wish to have. Sharing my thoughts here.

WHO guidelines rightly give importance to personal attributes in addition to a minimum level of educational qualifications, prior relevant work experience and basic cognitive skills. Something that can be said for any job.

My experience of working with the Community Health workers in outreach programs of Institutions during the early years of my career as a Developmental Pediatrician and the family-centric work with Community based rehabilitation workers (CRW) that I am associated with now as a part of NGO service made me understand that stringent selection criteria do not necessarily translate into quality work in the overall picture when it comes to Community based work.

The Major difference between the two forms of Community workers is that in the latter the recruitment is of persons belonging to the community chosen for work. The other important aspect is that the Health and Rehabilitation needs of people (children with Disabilities in our programme) are met in their own environment, involving family members and using the resources and support services in the community.

Much of what applies to CHWs in the context of UHC applies to CRWs in our resource-constrained settings. An explanation is in order for those not familiar with CBR workers/CRWs.

The need for a new cadre of worker in the rehabilitation field was advocated by WHO in 1981 because of shortage of highly trained

professionals to address the problem of disabilities in rural areas (besides the fact that professionals are used to working in technology oriented settings). In our own programme we felt there was a significant value in training Community workers to provide basic home based services (mainly therapy) on a daily basis. However, the level of education in the community was not high (a school leaving certificate in most cases). Hence, our preselection criteria included a grid which looked at 3 categories, viz. ESSENTIAL (basic cognitive skills, language proficiency, high school education, an understanding of local community, and an interest/willingness to learn), DESIRABLE (pleasant/cheerful personality, good communication skills, graduation, being a resident of the area or a place close by) and OPTIONAL (previous work experience, helping a friend or a family member with disability).

As for the two criteria of GENDER and MARITAL status, we did not also want to discriminate on the basis of the two criteria.

However, the choice was limited. We had approached a senior in the community (opinion builder) with a request to introduce us to a lady and a gentleman having good contacts in the neighborhood and who could guide us in recruiting CHWs. The first batch mostly had girls who couldn't get into college and women whose children were old enough to go to school on their own. The latter preferred to work part time in the neighborhood of their homes and with flexible schedules so as to be able to strike a balance between home and work. We had very few men applying. (We realised later that men prefer jobs with higher salaries and longer tenure.) The ratio of women to men was 8:2.

Having more senior women turned out well for us in the long run because being residents of the area the attrition level has been low. Retaining trained CRWs, who later gained proficiency with cumulative experiential learning over years, makes the initiative more sustainable. Younger females have to usually relocate due to reasons of marriage or maternity. Over a period of time we added mothers or siblings of children with special needs for they show greater empathy at work.

The less educated of the workers are often the best for practical work with mothers and children but the graduates are better at documentation of work. We continue with the practice of pairing the less educated older women (with better managerial skills) for work with the young graduates as they complement each other with their knowledge and skills.

I know that not all of the criteria apply to all CHWs and no single system is appropriate to all programmes. Area of coverage, interventions,

concomitant Community Development work, and the target beneficiaries often decide the criteria for selection.

Thanks and regards,

Sunanda

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HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

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## CHWs (82) Certification of CHWs

18 June, 2019

I noticed this article today on transfer of certification between provinces in Canada. Does anyone else have insights on CHW certification at the national or sub-national level (globally) and plans in place to enable workers to move within their country?

<https://globalnews.ca/news/5399527/b-c-care-providers-associations-files...>

HIFA profile: Catherine Kane is a member of the WHO Health Workforce team, responsible for advocacy and dissemination of the Guideline on health policy and system support to optimize community health worker programmes. She has experience with community health worker programmes at strategic and operational levels through WHO, the International Federation of Red Cross and Red Crescent Societies and at one point as a social worker supporting migrant communities. She is a member of the HIFA working group on CHWs. <http://www.hifa.org/support/members/catherine> Twitter: readycat

## CHWs (83) Kenya experience in CHW training

19 June, 2019

### Kenya Experience in CHW Training

A distinction is made between Community Health Extension Workers (CHEWs) and Community Health volunteers, both of which are often referred to as Community Health workers (CHWs).

The CHEWs function as link between formal health system and community system and supervise the CHVs

#### Competencies of CHEWs

1. Plan and mobilise resources to support health plans at community level
2. Manage/supervise/lead CHVs at community level
3. Communicate/coordinate stakeholders at community level
4. Supervise data collection, entry and dissemination
5. Monitor and evaluate programs at community level

#### Training

Training runs over a period of 6 months, implemented in a 3 phased approach, over a total of 30 days comprising 40 hours per week. It has a sandwich of 80 hours of community practice between the first two phases. Thus training involves 240 theoretical session contact hours and 160 hours of community partnership practice. Learning comprise knowledge, skills and attitudes and behaviour.

#### CHVs

CHWs advocate, facilitate and organize access to health and social services at community level. They serve as liaisons between household members and their health care providers. They visit patients in their home, and accompany them to clinical appointments. CHWs have frequent contact and conduct follow up with patients. The goal is to demonstrate improved care, improved health and lower costs.

Training of CHVs takes six weeks.

HIFA profile: Stephen Okeyo is the Dean at Great Lakes University of Kisumu-Tropical Institute of Community Health and Development (TICH) in Kenya. Professional interests: Reproductive Health; Public/Community Health (community based approaches); Health Policy and Systems; Quality of care; Academic Management and Leadership; Research Email address: [okeyo2012@gmail.com](mailto:okeyo2012@gmail.com)

## CHWs (84) Certification of CHWs (2)

19 June, 2019

[In response to Catherine Kane's question: Does anyone else have insights on CHW certification at the national or sub-national level (globally) and plans in place to enable workers to move within their country?]

In Nigeria the CHW/CHP are trained in the schools and colleges of health technology owned by each of the 36 states, but because they are all regulated by one national body (community health practitioners regulatory board- CHPRB), and the curriculum is handed down by the Board to each school/college, their certificates are interchangeable in practice should the CHW move from one state to another.

Joseph Ana.

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HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-

Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group and the HIFGA working group on Community Health Workers: <http://www.hifa.org/people/steering-group> jneana AT yahoo.co.uk

## CHWs (85) Certification of CHWs (3)

19 June, 2019

Recommendation 5 of the CHW Guideline says:

WHO suggests using competency-based formal certification for CHWs who have successfully completed pre-service training.

Certainty of the evidence - very low. Strength of the recommendation - conditional.

Here is the background to this recommendation (p43-44):

'A key component of quality health care delivery is workforce standards. This implies defining professional roles, scope of work, responsibilities and tasks, along with educational standards and minimum competency requirements for different health service positions. Credentialing provides a formal recognition awarded to those meeting predetermined standards (93). The availability of and requirements for CHW certification vary across countries. In many cases, CHWs have been identified as "community volunteers" and are casually trained to provide services in the community without any clear mechanism for certification. In some countries, however, standards and procedures for CHW certification exist.

'For CHWs, certification programmes might have some theoretical benefits: certification may increase their motivation, sense of self-esteem and respect from other health workers. Certification that describes the learning achieved enables transferability to other settings, thus reducing the need to repeat training if the worker moves location; or it can be used as evidence

as part of admission criteria for further education. In some countries, certification can legitimize the work of CHWs and provide opportunities for the reimbursement of CHW services (94). From the perspective of citizens and communities, formal certification may protect the public from harm resulting from the provision of inappropriate care rendered by providers lacking any training but purporting to be qualified (95).

'To reduce CHW drop-out rates and to ensure a sense of commitment to service, an earlier review suggested that CHW programmes should set up clear appointment and deployment strategies for CHWs who pass the final exam at the end of a training and receive a certificate of course completion (13). However, there is little formal evidence that suggests that certification improves outcomes. In this section, the guideline explores the evidence and provides policy guidance on competency-based, formal certification for CHWs who have successfully completed pre-service training.'

While preparing this discussion, the HIFA CHW working group suggested we put the following questions to the HIFA community to explore this issue further:

Does your country/program have a formal CHW Certification process in place or are you working toward on? If so, what is the process, what authority manages the certification process, and how often do CHWs have to re-certify?

What challenges exist in your setting regarding competency-based certification of CHWs?

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on

six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (86) Certification of CHWs (4)

19 June, 2019

Hi Catherine,

I don't know of many countries outside of the US, Canada and parts of Brazil that actually have formal CHW certification programs at this point. I pulled this resource from CHW Central on CHW Certification in the US which might interest you: <https://www.chwcentral.org/community-health-worker-training-and-certific...> (there are several others if you're interested in reading more). In the US, certification is on a state-by-state basis and for a CHW to work in another state, they would need to get certified for that state (much as lawyers need to take the bar for the state in which they operate). But transferability of certification raises an important question with regard to CHWs - is a CHW transferable and, if so, under what conditions? If one of the core criteria for the definition of a CHW is that they be from and reside in the community they serve, then it should not be possible for them to be re-located as a matter of standard practice. Of course people move and may want to continue working, so how would we manage/assess this?

In many countries, CHWs undergo a national training and, therefore, certification, were it to exist, would likely be national. In my view, CHWs should be able to continue operating as CHWs if they and their families move to new communities and if they can demonstrate a degree of integration into those new communities. What we want to avoid, however, is CHWs being deployed by health systems to communities where they have no deep connection - much like doctors and nurses are often deployed - that would, in my view, go against one of the core attributes of a CHW.

Of interest to you and others may also be the new National Association of Community Health Workers (NACHW) in the US. NACHW launched just this past April and is the first national community health worker association that I know of, though there is also the Community Health Worker Network of Canada <https://www.chwnetwork.ca/>, which has some similar aims to NACHW in the US. I have heard of some state associations of ASHA workers in India, but am not sure how active they are. I am sure one of our colleagues in India can jump in and add some detail on this. As these national associations and networks grow, they are likely to play a larger role in working with government to advance the CHW profession, including developing certification programs.

Best,

Becky

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## CHWs (87) Compilation of messages during week 2

20 June, 2019

Dear HIFA colleagues,

Please find here a compilation of messages during week 2 (7-13 June 2019), with thanks to HIFA volunteer Sam Pakenham-Walsh:

[http://www.hifa.org/sites/default/files/articles/CHW\\_discussion1\\_compila...](http://www.hifa.org/sites/default/files/articles/CHW_discussion1_compila...)

We hope you find this useful to review and contribute to the ongoing discussion.

The compilation of messages during week 1 is available here:

[http://www.hifa.org/sites/default/files/articles/CHW\\_discussion1\\_compila...](http://www.hifa.org/sites/default/files/articles/CHW_discussion1_compila...)

To contribute to the discussion, please send email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

With thanks, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: [www.hifa.org](http://www.hifa.org)

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (88) Integration of Ayurveda and Homeopathy practitioners? (4) Regulation of allied health professions

20 June, 2019

In South Africa there has been an attempt at regulating allied health professionals through The Allied Health Professions Council of South Africa (AHPCSA).

"The Allied Health Professions Council of South Africa (AHPCSA) is a statutory health body established in terms of the Allied Health Professions Act, 63 of 1982 (the Act) in order to control all allied health professions, which includes Ayurveda, Chinese Medicine and Acupuncture, Chiropractic, Homeopathy, Naturopathy, Osteopathy, Phytotherapy, Therapeutic Aromatherapy, Therapeutic Massage Therapy, Therapeutic Reflexology and Unani-Tibb. "

<https://ahpcsa.co.za/>

Have similar bodies been formed in India and Pakistan, given the wide belief and use of alternative medical practitioners. A process similar to AHPCSA would mean that practitioners would have to adhere to certain quality standards in order to be accredited.

I'm keen on hearing the experiences from other countries on this matter.

Kind regards

Maryam Rumaney

Maryam Bibi Rumaney  
Scientific & English language editing consultant

BSc[su], BSc(HONS)[su], MSc[uct]

[www.mbrumaney.co](http://www.mbrumaney.co)

HIFA profile: Maryam Rumaney currently works as a freelance scientific and English language editor. In addition, she offers consulting services to the laboratory industry.

## CHWs (89) Kenya experience in CHW training (2) NGOs and CHWs

20 June, 2019

Thank you, Stephen, for providing that detailed information about Kenya's CHW training protocols.

If possible, I am sure the group would appreciate hearing from some non-governmental organizations that also employ CHWs. If you are operating in a country that has some national guidelines, like Kenya, Uganda or Nigeria, do you have the same training duration and competencies? How do you coordinate with the national program regarding CHW selection and training? Hearing from these organizations would greatly enrich the conversation.

Thank you,

Amelia

HIFA profile: Amelia Plant is the Portfolio & Impact Manager at Preston-Werner Ventures, a San Francisco-based foundation looking to create scalable impact at the intersection of climate change and social justice. Amelia specializes in sexual reproductive health and rights, focusing on family planning information & access. She is currently based in Cairo, Egypt. She is a member of the HIFA working group on Family Planning and the HIFA wg on Community Health Workers.

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## CHWs (90) Competencies in curriculum for pre-service training (3)

20 June, 2019

Dear HIFA colleagues,

(btw Amelia, thanks for your message just now about NGOs - I do hope we can learn from their experience)

I am fascinated by Recommendation 3, which in my personal (non-expert) view is one of the most important of the 15 Recommendations. I reproduce below the Recommendation, the rationale for it, how the evidence should be interpreted (as described by the Guideline), and a personal comment from me.

### RECOMMENDATION 3

WHO suggests including the following competency domains for the curriculum for pre-service training of CHWs, if their expected role includes such functions.

Core:

- promotive and preventive services, identification of family health and social needs and risk;
- integration within the wider health care system in relation to the range of tasks to be performed in accordance with CHW role, including referral, collaborative relation with other health workers in primary care teams, patient tracing, community disease surveillance, monitoring, and data collection, analysis and use;
- social and environmental determinants of health;
- providing psychosocial support;
- interpersonal skills related to confidentiality, communication, community engagement and mobilization;
- personal safety.

Additional:

- diagnostic, treatment and care in alignment with expected role(s) and applicable regulations on scope of practice.

#### WHAT IS THE RATIONALE FOR RECOMMENDATION?

'The GDG recognized that the heterogeneity of roles played by CHWs requires and benefits from considerable flexibility in determining the contents of curricula for pre-service education. The logic underpinning the recommendation was that while roles - and thus competencies required - may vary, the general principle, supported by some limited evidence, is that the addition of specific competencies

and skills to the curriculum improves the capacity and performance of CHWs to perform the corresponding task(s). The recommendation was framed as a conditional one, recognizing both the importance of adapting it to national and local context and the moderate certainty and very limited scope of the underpinning evidence.'

#### HOW SHOULD WE INTERPRET THE EVIDENCE?

'The scope and roles of CHWs vary substantially across countries and CHWs, hence it is not possible to standardize the scope of pre-service education and contents of curricula. This is already reflected by the wide variations in the content of training curricula across countries, with some countries emphasizing predominantly competencies relating to reproductive, maternal, newborn and child health and others taking a broader approach. Some curricula, for example, focused exclusively on preventive and promotive interventions, while others also included diagnostic and curative competencies. The evidence identified through the systematic review, while of moderate certainty, refers to a single type of CHW in a single country, hence it is of limited generalizability and applicability. The inclusion of competencies in curricula should therefore be guided by requirements in the national context, while also reflecting international best practices, as also reflected in other WHO guidelines.'

COMMENT (NPW): This Recommendation, like most of the other recommendations, is conditional, emphasising the heterogeneity of most aspects of CHWs and CHW programmes, and the limitations of standardisation. The Recommendation goes further by stating 'it is not possible to standardize the scope of pre-service education and contents of curricula'. This is in stark contrast to some of the HIFA discussions we have had in previous years, where many (not all) HIFA members have advocated for standardisation of the CHW curriculum.

So how do we interpret this Recommendation and where should we go from here? Should each country sort out its own curriculum for CHWs (which, as we have seen in Nigeria, may be multilevelled)? Are there advantages to make training modular, so that all CHWs in a given country would have the same pre-service training, with the option to specialise later by taking further modules? Is there a case for standardising any of the curriculum, whether globally or regionally? What does all this mean for sharing of experience and expertise among different countries?

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: [www.hifa.org](http://www.hifa.org)

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

Here is the text from the Guideline (page 35):

#### 7.1.5 Implementation considerations

Successful pre-service selection is likely to involve more than screening formal qualifications of candidates, such as their level of education. Individual attributes and values to consider in the selection process may include relevant cognitive skills, prior relevant work experience, a demonstrated commitment and attitude to community service, leadership skills, being proactive, cooperative and adaptable, and the capacity and willingness to progressively develop an understanding of the local context and community. It may be important to complement screening and selection with community involvement; the selection of an eligible CHW from within

the community may also facilitate the delivery of more linguistically and culturally appropriate services.

Where a CHW from outside the community must be selected (for example, because no one from the community wants to perform the task or meets the minimum requirements to serve in that role), ensuring that the community members still have a voice may improve the chances that the CHW will be integrated and that they can more meaningfully help the health organization tailor services to local needs. In

addition, community participation in CHW recruitment and selection enables a dialogue between community members and health organizations, helping them understand local issues. The selection process should take into account the values of the inherent community structures. Potential for bias and discrimination should be avoided. In some contexts, preferential selection of female CHWs for the delivery of

reproductive, maternal, newborn and child health services may be necessary to ensure acceptability by communities.

Community and end-users may need to take into consideration as selection criteria core values and attributes of the candidates.

The selection criteria should take into consideration acceptability and feasibility, as well as suitability in the local context and in relation to the needs of the end-users of services.

Reference: WHO Guideline on health policy and system support to optimize community health worker programmes (CHW Guideline)

<https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-en...>

Comment (NPW): The above represents a succinct, commonsense summary of the Recommendation, but I wonder if something more is needed to support/promote actual implementation? This is perhaps an area where HIFA members can bring additional perspectives from your own experience. Do any HIFA members have experience of selecting CHWs for pre-service training? If so, it would be great to learn from you. What criteria did you use for selection and what process did you use? What challenges did you face and how did you deal with these?

To what extent does the Guideline address the issues around selection of CHWs for pre-service training? What additional tools might be needed to support such selection at national and local levels?

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: [www.hifa.org](http://www.hifa.org)

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (91) Modalities of pre-service training

22 June, 2019

Dear HIFA colleagues,

Recommendation 4 of the WHO Guideline on CHWs is about 'modalities' (training approaches/methods)

### RECOMMENDATION 4

WHO suggests using the following modalities for delivering pre-service training to CHWs:

- balance of theory-focused knowledge and practice-focused skills, with priority emphasis on supervised practical experience;
- balance of face-to-face and e-learning, with priority emphasis on face-to-face learning, supplemented by e-learning on aspects on which it is relevant;
- prioritization of training in or near the community wherever possible;
- delivery of training and provision of learning materials in language that can optimize the trainees' acquisition of expertise and skills;
- ensuring a positive training environment;
- consideration of interprofessional training approaches where relevant and feasible.

Certainty of the evidence - very low. Strength of the recommendation - conditional.

Here is the background to the recommendation:

'Meeting the various needs of a community entails CHWs having the required core competencies in relation to their role. Such competencies and attributes can be built and honed through proper and adequate training. In some cases, access to training has been an important factor in CHW retention. There are several approaches for the training of CHWs, including short-term courses, long-term certificate programmes and distance learning, all of which use different delivery modalities, from didactic face-to-face classroom teaching to web-based online courses for self-guided learning.

'While face-to-face didactic classroom teaching was the dominant training modality until the early 1990s, web-based learning is increasingly used for training purposes. Although e-learning is still restricted to geographical settings with higher connectivity to web-based portals, increased access to the Internet and rapid growth in technology are providing enhanced opportunities to develop health care worker training programmes, upgrade health care services and strengthen health care systems.

'The broader policy discourse on education of other health workers in recent years has identified a number of issues contributing indirect evidence that can be considered also in the education of CHWs, including the potential for broadening the focus of health education to enable health workers to be change agents in the communities they serve; the opportunities opened by interprofessional education approaches; and the link between locating education institutions and training in underserved areas and the retention of health workers in these settings.'

## QUESTIONS FOR DISCUSSION

How does this Recommendation relate to current practice in your country/experience?

If you are a CHW trainer or programme manager, what methods do you currently use to deliver pre-service training for CHWs? What works and what doesn't in your context?

If you are a CHW, we would love to hear from you. What has been your experience of pre-service training? How might it be improved in the future?

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (92) 2nd International Symposium on Community Health Workers, Dhaka, 22-24 November, 2019 (2)

22 June, 2019

Will you be going to the 2nd International Symposium on Community Health Workers, Dhaka, 22-24 November, 2019?

Note that: 'Scholarship will be provided to young and emerging researchers of low- and middle- income countries (LMIC's) - Scholarship includes flight, and food, and accommodation for three days. Scholarship will be provided to young and emerging researchers of low- and middle- income countries (LMIC's) - Scholarship includes flight, and food, and accommodation for three days.' This statement is given as part of the Abstract Submission Instructions: [http://chwsymposium2019.icddr.org/abstract\\_submit](http://chwsymposium2019.icddr.org/abstract_submit)

I suspect that sponsorship would apply only to selected researchers whose abstracts have been accepted for presentation. Nevertheless, this seems an excellent opportunity for HIFA members to apply. I think the first would be to plan and submit your abstract for an oral or poster presentation.

The deadline for abstract submission is 31 July according to the website, although the current Health Systems Global newsletter suggests it is 30 June.

If you are planning to give a presentation, you may like to consider inclusion of a section about HIFA generally and our HIFA project on CHWs specifically. Let me know if you're interested. [neil@hifa.org](mailto:neil@hifa.org)

The conference website is here: <http://chwsymposium2019.icddrb.org/>

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (92) Competencies in curriculum for pre-service training (4) Modalities of pre-service training (2)

22 June, 2019

Hello!

This is to share a few thoughts on Recommendation 3 of WHO Guidelines, and to extend the discussion to optimal approaches to the training in relation to implementation of the program.

Countries like Nigeria, Kenya and Uganda have planned their services with a degree of standardisation of curricula in the context of their Health Systems based on existing National programs and perhaps will find it easier build on the best practices to meet the guidelines. So also with some of the developing countries in Asia - Bangladesh, India, Nepal, - all gearing towards UHC but unsure as to the integration of CHWs in implementation of UHC.

Thailand has been ahead of others in going towards UHC with CHWs well incorporated into the System and may have lessons for us.

We will perhaps have to look beyond the heterogenous nature of CHWs in this debate and discourse about Standard curriculum for training. Given the heterogeneity of the building blocks of Health Systems (especially Governance and finances), I feel a standard curriculum can at best be planned for a country.

As for India, inequity poses a big challenge in pre-service selection on several counts, the level of education being one of them. We have marked regional differences in terms of Health indices, disease patterns, access to services and our National programs could do well to recognise those in implementing interventions for prevention, health promotion, referrals, curative service support, rehabilitation, or other.

The GDG [Guideline Development Group] recommendation for flexibility in curriculum or training process is justified even if the current evidence does not fully support it. There is no definitive evidence to the contrary either. The best practices are so varied in different situations even if we are to go by the NGO implemented projects. Most of the time, NGO programs with CHWs are designed to fill some gaps in the System rather than to integrate CHWs into the System. The applicability on a wider scale is not easy even when the Public-Private/NGO-Community partnerships manage to meet the local needs or program objectives with some grassroots convergence.

I am herewith sharing an evidence-based policy brief from a project (ANCHUL) by IIPH Delhi, (PHFI) where the team adopted principles of Implementation research to identify optimal approaches for a particular setting with the principal objective to develop intervention targeted towards ASHA workers (CHW) for improved processes to optimize or enhance their work performance.

It is possible we have some key findings here that one might want to refer to again while discussing a couple of other WHO recommended guidelines.  
[\*see note below]

[https://phfi.org/wp-content/uploads/2019/06/anchul\\_4\\_page\\_policy\\_brief- ...](https://phfi.org/wp-content/uploads/2019/06/anchul_4_page_policy_brief-...)

Thank you.

Best regards,

Sunanda

Dr. Sunanda K. Reddy

Chairperson (Honorary), CARENIDHI

Adjunct Faculty, SACDIR, IIPH Hyderabad

Phone: +91-9818621980, +91-9560302666

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

<http://www.hifa.org/projects/community-health-workers>

<http://www.hifa.org/support/members/sunanda>

write2sunanda AT gmail.com

[\*Note from HIFA moderator (Neil PW): Thank you Sunanda. For the benefit of those who may not have immediate web access, this policy brief is titled: 'Planning, Implementation and Effectiveness of ANCHUL (AnteNatal and Child Health care in Urban sLums) intervention'. The brief is prepared by the ANCHUL project team at Indian Institute of Public Health-Delhi, Public Health Foundation of India. The ANCHUL intervention is an innovative approach to ASHA programming and 'has a specific focus on selection, training, monitoring and supervision of ASHAs with smooth execution of their day to day activities using job aids and effective use of data'.]

## CHWs (94) The impact of the Ethiopian health extension program and health development army on maternal mortality

23 June, 2019

A new paper in Social Science and Medicine concludes 'it is hard to escape the idea that the HEP/HDA [Health Extension Program/Health Development Army] had a substantial effect on reducing maternal mortality'.

Citation, abstract and a comment from me below.

CITATION: Rieger M, Wagner N, Mebratie A, Alemu G, Bedi A. The impact of the Ethiopian health extension program and health development army on maternal mortality: A synthetic control approach.

Soc Sci Med. 2019 Jul;232:374-381. doi: 10.1016/j.socscimed.2019.05.037. Epub 2019 May 22.

### ABSTRACT

The Ethiopian government has implemented nationwide strategies to improve access to basic health services and enhance health outcomes. The Health Extension Program (HEP) launched in 2003, expanded basic health infrastructure and local human resources. In 2011, the government introduced the Health Development Army (HDA). HDA is a women-centered community movement inspired by military structures and discipline. Its special objective is to improve maternal health outcomes. This paper uses a synthetic control approach to assess the effects of HEP and HDA on maternal mortality ratios (MMR). The MMR data are from the Global Burden of Diseases (GBD) database. A pool of 42 Sub-Saharan African countries, covering the period 1990 to 2016, is used to construct a synthetic comparator which displays a mortality trajectory similar to Ethiopia prior to the interventions. On average, since 2004, maternal mortality in the control countries exhibits a moderate downward trend. In Ethiopia, the downward trend is considerably steeper as compared to its synthetic control. By 2016, maternal mortality in Ethiopia was lower by 171 (p-value 0.048) maternal deaths per 100,000 live births as compared to its synthetic control. Between 2003 and 2016, Ethiopia's maternal mortality ratio declined from 728 to 357. These estimates suggest that a substantial proportion of this decline may be attributed to HEP/HDA. The Ethiopian experience of enhancing nation-wide access to and use of maternal health services in a short time-span is remarkable. Whether such a model may be transplanted is an open question.

COMMENT (NPW): The HEP and its constituent HDA are a nation-wide community-based health initiative, based primarily on trained CHWs (Community Health Extension Workers). The statistics are impressive. Looking at the full text of the paper, it is notable that there has been a complementary massive increase in infrastructure also: 'Between 2000 and 2015 there has been a 20-fold increase in the number of health posts, a 10-fold increase in the number of health centers and a fourfold increase in the number of public hospitals.'

It would be interesting also to see corresponding data on neonatal mortality.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: [www.hifa.org](http://www.hifa.org)

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (95) Good governance in primary health care for all: the role of WHO and individual governments

23 June, 2019

Good governance in primary health care for all: the role of WHO and individual governments (CHW # 95)

I am following the article posted by fellow HIFA members CHW #94 to highlight good governance in primary health care (abstract included below). Rieger M, Wagner N, Mebratie A, Alemu G, Bedi A. The impact of the Ethiopian health extension program and health development army on maternal mortality: A synthetic control approach. Soc Sci Med. 2019

Jul;232:374-381. doi: 10.1016/j.socscimed.2019.05.037. Epub 2019 May 22.

Average life expectancy in Ethiopia in 1960 was age 38, in 2000 it was age 52 and in 2018 it reached age 67. By any standard the last increase in life expectancy of age 15 years in 18 years should be considered unprecedented.

Good governance in primary health care is achieved when governments implement the established WHO regulations and standards as their national policies. Without good governance in primary healthcare it is safe to assume that the current good health and longevity could not be achieved globally. In 1948, when WHO was established, average global life expectancy was approximately 48.

All previous Director Generals of WHO have left their marks and made the world a better place. This brief response acknowledges three of them:

In 1967, WHO Director General Gomes Cadau, MD of Brazil presided over the eradication of smallpox, the only disease to be eradicated globally. For this to happen, WHO and all governments of all nations had to collaborate, which meets the definition of good governance in health.

In 1978, WHO Director General Dr Halfdan Theodor Mahler, MD of Denmark presided over the Alma Ata Declaration, also known as primary healthcare for all by the 2000, which resulted in substantial increases in life expectancy in developing countries, which also meets the definition of good governance in health.

In 2005 - 2012, in Ethiopia, the Minister for Health presided over a policy that promoted the expansion of community healthcare workers throughout the country, referred to in the article as Health Development Army (HAD), by hiring, training and dispatching more than 38,000 community health workers. That Minister is the current Director General of the WHO, Tedros Adhanom, MD, of Ethiopia. If Director General Adhanom could do for Africa what he did for Ethiopia, there will be no one left behind and it is safe to assume that the global average life expectancy will exceed age 70 in his first term and age 75 in his second term. In order for this to happen, governments of Africa, WHO and OECD member countries must work in collaboration, focusing on the underserved, expanding primary healthcare for all to include HPV vaccines for boys and girls age 12, as Australia did, and also preparing for emerging trends such as the aging of the global population and the impact of climate change on health.

Included here for reference:

## ABSTRACT

The Ethiopian government has implemented nationwide strategies to improve access to basic health services and enhance health outcomes. The Health Extension Program (HEP) launched in 2003, expanded basic health infrastructure and local human resources. In 2011, the government introduced the Health Development Army (HDA). HDA is a women-centered community movement inspired by military structures and discipline. Its special objective is to improve maternal health outcomes. This paper uses a synthetic control approach to assess the effects of HEP and HDA on maternal mortality ratios (MMR). The MMR data are from the Global Burden of Diseases (GBD) database. A pool of 42 Sub-Saharan African countries, covering the period 1990 to 2016, is used to construct a synthetic comparator which displays a mortality trajectory similar to Ethiopia prior to the interventions. On average, since 2004, maternal mortality in the control countries exhibits a moderate downward trend. In Ethiopia, the downward trend is considerably steeper as compared to its synthetic control. By 2016, maternal mortality in Ethiopia was lower by 171 (p-value 0.048) maternal deaths per 100,000 live births as compared to its synthetic control. Between 2003 and 2016, Ethiopia's maternal mortality ratio declined from 728 to 357. These estimates suggest that a substantial proportion of this decline may be attributed to HEP/HDA. The Ethiopian experience of enhancing nation-wide access to and use of maternal health services in a short time-span is remarkable. Whether such a model may be transplanted is an open question.

COMMENT (NPW): The HEP and its constituent HDA are a nation-wide community-based health initiative, based primarily on trained CHWs (Community Health Extension Workers). The statistics are impressive. Looking at the full text of the paper, it is notable that there has been a complementary massive increase in infrastructure also: 'Between 2000 and 2015 there has been a 20-fold increase in the number of health posts, a 10-fold increase in the number of health centers and a fourfold increase in the number of public hospitals.'

HIFA profile: Enku Kebede-Francis (PHD, MS, MEd) is an advisor in global health governance. She has worked for the United Nations (UNESCO, UNDP, UNFPA and UNDPI); was an Assistant Professor at Tufts University Medical School/Department of Public Health; and, a Visiting Scientist at the USDA's Center for Human Nutrition Research Center for Aging and a Visiting Fellow at the Australian National University Medical School. She also designed and implemented preventive health programs promoting women's health and tobacco cessation programs in Croatia and worked on addiction prevention programs in Florida and Massachusetts, USA. Her professional interests

include preventing scurvy and childhood blindness in developing countries using micronutrients. An advocate for primary healthcare for all as a right, she published a textbook in 2010, Global health Disparities: closing the gap through good governance.

## CHWs (96) Modalities of pre-service training (3) ANCHUL (AnteNatal and Child Health care in Urban sLums)

24 June, 2019

Dear HIFA colleagues,

Sharing herewith a link to the work of Anchul team again. Also attached is the Pdf version. [\*see note below]

This comes to you now on behalf of Dr. Suparna Ghosh (also a HIFA member) who was the Principal investigator. She is currently busy with a research project in the interior remote areas with poor net connectivity. Hence, I am sharing this with you now because there is much here that is relevant for the current discussion on CHWs.

<https://phfi.org/wp-content/uploads/2019/06/ANCHUL-Toolkit-Final.pdf>

Thanks and regards,

Sunanda

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

<http://www.hifa.org/projects/community-health-workers>  
<http://www.hifa.org/support/members/sunanda>  
write2sunanda AT gmail.com

[\*Note from HIFA moderator (Neil PW): HIFA does not carry attachments. The PDF is available at the above URL.]

## CHWs (97) Understanding the challenges faced by CHWs

25 June, 2019

I have been based in Mukono, Uganda for the past 10 months working with a small group of 14 Village Health Team members. The project has had three main phases: 1. Conduct a period of indepth qualitative participatory work to understand the challenges faced by CHWs in this area; 2. Co-design an intervention to improve supervision and address some of the challenges working with CHWs, NGOs, District Health Officials and WHO; 3. Implement and evaluate the programme.

I have established a very active WhatsApp group with the 14 CHWs. I am sure they would be happy to be in touch. [\*see note below]

Best wishes,

James

HIFA profile: James O'Donovan is a doctor and a DPhil candidate at Oxford University, UK. His research interests include the use of mobile phones for community health workers in low- and middle-income countries. He is a member of the HIFA working group on CHWs.

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[\*Note from HIFA moderator (NPW): Thank you James. Giving CHWs a voice is critical (and challenging) and HIFA would love to connect with the 14 Village Health Team members in your group. You are best placed to suggest how, but possibilities might include:

1. making them aware of the CHW Guideline and perhaps select specific aspects that may be of interest to them, and ask what they think

2. making them aware of HIFA and how to join
3. for those unable to join, offering to share their (anonymised) views and perspectives
4. sharing with HIFA what you have learned so far 'to understand the challenges faced by CHWs' in this group.

Are any other HIFA members in direct contact with CHWs? Please get in touch.]

## CHWs (98) Compilation of messages during week 3

25 June, 2019

Dear HIFA colleagues,

Thank you for all your contributions to this important discussion!

Please find here a compilation of messages during week 3 (14-20 June 2019), with thanks to HIFA volunteer Sam Pakenham-Walsh:

[http://www.hifa.org/sites/default/files/articles/CHW\\_discussion1\\_compila...](http://www.hifa.org/sites/default/files/articles/CHW_discussion1_compila...)

We hope you find this useful to review and contribute to the ongoing discussion.

Background to the discussion and all compilations are available here:

[http://www.hifa.org/sites/default/files/articles/CHW\\_discussion1\\_compila...](http://www.hifa.org/sites/default/files/articles/CHW_discussion1_compila...)

(scroll down to see the PDF links)

To contribute to the discussion, please send email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

With thanks, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (99) Understanding the challenges faced by CHWs (2)

26 June, 2019

Hi James. [James O'Donovan, UK/Uganda: <http://www.hifa.org/dgroups-rss/chws-97-understanding-challenges-faced-chws> ]

I am interested in the feedback from the CHWs. I have been working with communities in south east Nigeria and we are designing a project to develop an informal group of CHWs to meet the needs of hard to reach communities. Their health care needs are far from being met and the formal sector (primary health care structure) is very weak. It is important to have the commitment of all stakeholders in making the system an effective one. Sadly this is lacking at the community level and this can sometimes affect the work that the CHWs can do. Information from your group of CHWs would be helpful in the conversations with the community on the implementation of this activity.

Thanks.

Ranti Ekpo

Ranti Ekpo is Program Manager/Researcher at the dRPC in Nigeria. Professional interests: Health Advocacy, Child Health, Child diarrhoea, Childhood Pneumonia, Child Nutrition, Routine Immunisation, Family Planning. ekpooy AT yahoo.co.uk

## CHWs (100) Understanding the challenges faced by CHWs (3)

27 June, 2019

It is critical to discuss HOW we engage the CHWs. I would be interested in this discussion on pedagogy.

I subscribe to Paulo Freire and the works influenced him. It is also worthwhile to look at the SALT approach. [\*see notes below]

HIFA profile: Kausar Skhan is with the Community Health Sciences Dept of Aga Khan University, Karachi, Pakistan. kausar.skhan AT aku.edu

[\*Note from HIFA moderator (Neil PW):

1. Paulo Freire (1921 - 1997) was a Brazilian educator and philosopher who was a leading advocate of critical pedagogy. He is best known for his influential work, *Pedagogy of the Oppressed*, which is generally considered one of the foundational texts of the critical pedagogy movement. [https://en.wikipedia.org/wiki/Paulo\\_Freire](https://en.wikipedia.org/wiki/Paulo_Freire)

2. Advocates of critical pedagogy view teaching as an inherently political act, reject the neutrality of knowledge, and insist that issues of social justice and democracy itself are not distinct from acts of teaching and learning. The goal of critical pedagogy is emancipation from oppression through an awakening of the critical consciousness, based on the Portuguese term *conscientização*. When achieved, critical consciousness encourages individuals to effect change in their world through social critique and political action. [https://en.wikipedia.org/wiki/Critical\\_pedagogy](https://en.wikipedia.org/wiki/Critical_pedagogy)

3. SALT Approach (Stimulate, Appreciate, Listen/Learn, Transfer) <http://www.cominit.com/polio/content/polio-project-using-salt-approach-...> ]

## CHWs (101) Understanding the challenges faced by CHWs (4)

27 June, 2019

The effective and efficient use of CHWS whether they are TBAs or malaria agents or any other sectors specific is as alternative source. In Eritrea we

were training and equipping Comprehensive CHWs in very remote hard to access (transport wise) villages.

Train them in CIMCI [Community Integrated Management of Childhood Illness], malaria control, sanitation and disease prevention and they will help. If there is a trained TBA who can advise a pregnant mother the advantages of delivering in a health facility she has done a lot of help. The other concern is the issue of remuneration without an incentive it would be incomplete lets learn the lesson from Ethiopia about that. IN Bodies can contribute a lot in those countries who cannot afford to do that. WHO guideline is not enough. Let the rich countries start the commonly accepted approach to solve the problem of access. It is obvious A comprehensive CHW is a solution in the right place.

HIFA profile: Toumzghi Sengal is a physician assistant and currently works as editor and free lance consultant in Eritrea and East Africa region. toumzghisen11 AT gmail.com skype:toumsen13 He is a HIFA Country Representative

<http://www.hifa.org/support/members/toumzghi-0>

## CHWs (105) Henry Perry: Progress in the revitalization of primary health care and recent publication of interest

27 June, 2019

Dear HIFA colleagues,

I received today an email from Henry Perry (a leading global and community health expert at the Johns Hopkins Bloomberg School of Public Health), who notes 'The growing leadership of the World Health Organization in primary health care as the means to achieve Universal Health Coverage and its growing support for large-scale community health programs is exciting to see.' "Feel free to share this with any individuals (or any listserv of individuals) you think might be interested", he says. I am sure everyone on HIFA will be interested to read what he says:

Dear colleagues and friends:

I hope you are doing well. This is a listserv broadcast to those of you I know with an interest in primary health care and community health. Apologies for the formality of this communication.

The past two years have been a great time for those of us with a passion for the potential of primary health care (including community-based service delivery and community engagement) for improving the health of populations around the world. One of the most important advances for the movement to revitalize primary health care has been the installation of Dr. Tedros Adhanom Ghebreyesus as Director General of the World Health Organization, whose campaign platform for his election was based on his achievements as the Minister of Health of Ethiopia in transforming its national primary health care program through the training of 38,000 Health Extension Workers, one for every 2,500 people in the country, and the benefits for population health that resulted. At the World Health Assembly just a few weeks ago (on 20 May 2019), Tedros's keynote address including the following:

“The Declaration of Astana, endorsed by all 194 Member States last year, was a vital affirmation that there will be no UHC [Universal Health Coverage] without PHC. Primary health care is where the battle for human health is won and lost. Strong primary health care is the front line in defending the right to health, including sexual and reproductive rights. It's through strong primary health care that countries can prevent, detect and treat noncommunicable diseases. It's through strong primary health care that outbreaks can be detected and stopped before they become epidemics. And it's through strong primary health care that we can protect children and fight the global surge in vaccine-preventable diseases like measles.... Of course, strong primary health care depends on having a strong workforce, working in teams. Doctors, nurses, midwives, lab technicians, community health workers - they all have a role to play.” (available at [http://apps.who.int/gb/ebwha/pdf\\_files/WHA72/A72\\_3-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_3-en.pdf))

Last fall, the world celebrated the 40th anniversary of the Declaration of Alma-Ata at Astana, Kazakhstan, resulting in the Declaration of Astana, mentioned by Dr. Tedros above, which reaffirmed the principles of primary health care as embodied in the Declaration of Alma-Ata (available at <https://www.who.int/docs/default-source/primary-health/declaration/gcphc...>). The “WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes” was released at the Astana Conference. A copy is attached and is also available at <http://socialserviceworkforce.org/resources/who-guideline-health-policy-...>. An abridged version of this was published in Lancet Global Health and is attached (Cometto 2018).

In December 2018, Director-General Tedros gave a report to the Executive Board of the World Health Assembly entitled “Community health workers delivering primary health care: opportunities and challenges” (available at [http://apps.who.int/gb/ebwha/pdf\\_files/EB144/B144\\_2-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB144/B144_2-en.pdf)) which called on countries to consider the value of integrating CHWs into health systems for the long term. This was followed by a report of the Executive Board of the World Health Assembly in January 2019 entitled “Community health workers delivering primary health care: opportunities and challenges” (available at [http://apps.who.int/gb/ebwha/pdf\\_files/EB144/B144\\_R4-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB144/B144_R4-en.pdf)) recommended that the World Health Assembly adopt a resolution that called upon member states to implement the WHO guidelines on CHWs and to recognize the importance of CHWs for achieving Universal Health coverage. In May 2019 the World Health Assembly passed a historic, first ever resolution on CHWs recognizing the essential role the CHWs play in delivering primary health care and the need for better integration into and support from health systems (available at: [http://apps.who.int/gb/ebwha/pdf\\_files/WHA72/A72\\_R3-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_R3-en.pdf)).

Of particular note has been the strong progress made in the recognition of the value of community health workers for strengthening primary health care systems and improving population health. Over a two-year period, the World Health Organization led a process for developing national guidelines for CHW programs. A team I led had the privilege of carrying out a systematic review of reviews that had been published in the peer-reviewed literature. This review turned out to be foundational for the guidelines that we were released in the fall. Our paper was published in Human Resources for Health last fall (Scott et al., 2018, attached).

I am pleased to share with you some other publications that I have been most fortunate to help with that have been published over the past year. These publications are all open access, so feel free to share them with any individuals or listservs that have an interest in these topics.

One article (Perry 2018 - PHC Redefinition) provides my view of how the Alma-Ata definition of PHC might be updated to address 21st century realities. This arose originally from a consultation I carried out in 2013 with the Gates Foundation. Two articles (O’Conner 2019 and Hutain 2019) describe some pioneering work in the slums of Freetown, Sierra Leone on engaging communities to understand and address their health problems with the assistance of a leading NGO, Concern Worldwide. Another article (Perry & Rohde 2019) describes the groundbreaking and ongoing work of the Comprehensive Rural Primary Health Project in Jamkhed, India - now approaching 50 years of community health worker deployment and community engagement. Finally, a book review I wrote addresses some important issues about payment of volunteer CHWs.

The growing leadership of the World Health Organization in primary health care as the means to achieve Universal Health Coverage and its growing support for large-scale community health programs is exciting to see.

Thanks for your interest in and commitment to primary health care and community health! Feel free to share this with any individuals (or any listserv of individuals) you think might be interested.

Best wishes,

Henry

Henry B. Perry, MD, PhD, MPH  
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Note: The original email had several attachments but HIFA does not carry attachments. If you would like me to forward the original email with attachments, just let me know: [neil@hifa.org](mailto:neil@hifa.org)

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (106) CHWs in Uganda

27 June, 2019

### HEALTH ASSISTANTS IN UGANDA IS UNTAPPED OPPORTUNITY

In Uganda Health Assistants are trained community Health Workers. There is a significant number of them unemployed. They are well trained to work and serve villages and parishes as Health promoters.

There is need to explore more and invest resources in community based health services and health information especially in Sub Saharan Africa.

The health sector staffing at national and local government levels need restructuring to establish Health Assistant position at Parish Level, Health Inspector position at Sub County Level, Environmental Health Officer at County Level and Assistant District Health Officer at District Level.

Critical professionals for community based Health Services are required to achieve health for all. Community led primary health care interventions need specially trained health cadres who are Health Assistants, Health Inspectors etc and provision of modest resources required for them to deliver community based health services.

Benon Ndemere

Senior Environmental Health Officer/Community Based Education Facilitator.

HIFA profile: Ndemere Rukara Benon is a Senior Environmental Health Officer at Uganda Prisons Service in UGANDA. Professional interests: Community based health programming, monitoring, evaluation and financing. Email address: ndemereb76 AT gmail.com

## CHWs (107) Reflections on CHW Discussion Week 3

30 June, 2019

During week 3, we discussed length of CHW training, competency domains, and modalities.

CHWs often provide sexual and reproductive information and services. On June 17th, our colleague from IBP, Nandita, shared some useful resources that delve more deeply into best practices and case studies. One such

resource is the "WHO Summary Brief on Task Sharing to Improve Access to Family Planning/Contraception," published 2017. On page 7, it states:

"There needs to be more rigorous evidence about the effectiveness or acceptability of lay health workers providing injectable contraceptives in various contexts or conditions, especially when being considered for implementation and scaling up. Particular attention must be given to specific issues such as risks or harms for which little or no relevant information is available."

It is now becoming more common for CHWs to provide both depo provera (DMPA-IM) and sayana press (DMPA-SC). This is an example of how the "competency domains" can be quickly expanded as new treatments and/or knowledge becomes available. This WHO summary brief and other such statements should be living documents, quickly incorporating new pilots and shifting recommendations so that all governments and NGOs that work with CHWs are well-informed about the kinds of tasks that CHWs may take on.

Sunanda's contribution on June 18th provided quite useful implementation concerns about CHW selection. I particularly appreciated the following:

"The less educated of the workers are often the best for practical work with mothers and children but the graduates are better at documentation of work. We continue with the practice of pairing the less educated older women (with better managerial skills) for work with the young graduates as they complement each other with their knowledge and skills."

These are the kinds of on-the-ground experiences that are difficult to capture in guidelines with large scopes and overarching questions, but are nevertheless extremely valuable. I hope those working with CHWs utilize online fora, such as CHW Central, or in-person conferences, as the CHW Symposium (Dhaka, Bangladesh in November), to take heed of these experiences in implementation.

Lastly, Neil raised quite a useful set of questions regarding the competency domains covered in pre-service training. One such question was, "Are there advantages to make training modular, so that all CHWs in a given country would have the same pre-service training, with the option to specialise later by taking further modules?"

I wonder how that would affect the community members' understanding of the roles of CHWs, and usage thereof. Would it just spread through a community that their CHW now had a particular test or new service? Or would there be any confusion caused if certain CHWs covered a particular

specialization and others did not? How does that work now in villages where multiple NGOs train CHWs to do slightly different work?

Thanks,

Amelia

HIFA profile: Amelia Plant is the Portfolio & Impact Manager at Preston-Werner Ventures, a San Francisco-based foundation looking to create scalable impact at the intersection of climate change and social justice. Amelia specializes in sexual reproductive health and rights, focusing on family planning information & access. She is currently based in Cairo, Egypt. She is a member of the HIFA working group on Family Planning and the HIFA wg on Community Health Workers.

<http://www.hifa.org/support/members/amelia>

<http://www.hifa.org/projects/family-planning>

Email address: asiplant AT gmail.com

## CHWs (108) Certification of CHWs (5)

30 June, 2019

Thanks as ever for your inputs. Special thanks to HIFA volunteers Amelia Plant (weekly reflections) and Sam Pakenham-Walsh (compilations).

We now move into the penultimate week of our first (of three) thematic discussion on CHWs and the WHO Guideline: Health policy and system support to optimize community based health worker programmes.

This week we invite you to comment on Recommendation 5 of the Guideline:

### Recommendation 5

WHO suggests using competency-based formal certification for CHWs who have successfully completed pre-service training.

Certainty of the evidence - very low. Strength of the recommendation - conditional.

How does this Recommendation relate to current practice in your country/experience? Is it implementable in your country/experience?

The guideline notes that certification 'can be a pathway to greater competency of CHWs (and hence improved patient safety through better quality of care). Further, it can enhance credibility, recognition and employability of CHWs'. It notes also: 'From the perspective of citizens and communities, formal certification may protect the public from harm resulting from the provision of inappropriate care rendered by providers lacking any training but purporting to be qualified'.

'In some countries this could also be a requisite for authorization of practice, and the pathway to formal contracting, remuneration, and the availability of opportunities for career progression'

You can read details of Background, Rationale, Summary of evidence, Interpretation of evidence, and Implementations considerations in relation to Recommendation 5 on pages 43-5 of the Guideline:

<https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-en...>

We look forward especially to hear from CHW programme managers, trainers and community health workers themselves. You can contribute to the discussion by sending an email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

Remember, we welcome and encourage contributions on \*any\* aspect of CHWs at any time.

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (92) 2nd International Symposium on Community Health Workers, Dhaka, 22-24 November, 2019 (3)

1 July, 2019

Dear Colleagues,

Given our experience of hosting the first International Symposium on Community Health Workers that was held in Uganda in 2017 and attended by over 450 participants from 22 countries, I would strongly encourage those working with or having interest in CHWs to plan to attend this event to be held in Bangladesh later this year. The 2nd international symposium will provide opportunities for networking, sharing experiences and best practices, as well future collaboration.

[ <http://chwsymposium2019.icddr.org/> ]

Best wishes,

Dr. David Musoke

Department of Disease Control and Environmental Health

School of Public Health

Makerere University College of Health Sciences

P. O. Box 7072, Kampala, Uganda

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HIFA profile: David Musoke is a Lecturer at the Makerere University School of Public Health, Uganda. Professional interests: Malaria prevention, community health workers, environmental health, public health, disadvantaged populations. He is a member of the HIFA working group on CHWs.

[www.hifa.org/projects/community-health-workers](http://www.hifa.org/projects/community-health-workers)

[www.hifa.org/support/members/david-0](http://www.hifa.org/support/members/david-0)

Email: dmusoke AT musph.ac.ug

## CHWs (110) What are the effective elements in patient-centered and multimorbidity care? A scoping review

1 July, 2019

(h/t Alberto Fernandez, EASP/WHO-CC, lead moderator HIFA-Spanish)

Citation, abstract and comment from me below.

CITATION: BMC Health Serv Res. 2018 Jun 14;18(1):446. doi: 10.1186/s12913-018-3213-8.

What are the effective elements in patient-centered and multimorbidity care? A scoping review.

Poitras ME1, Maltais ME2, Bestard-Denommé L3, Stewart M3, Fortin M2.

## ABSTRACT

**BACKGROUND:** Interventions to improve patient-centered care for persons with multimorbidity are in constant growth. To date, the emphasis has been on two separate kinds of interventions, those based on a patient-centered care approach with persons with chronic disease and the other ones created specifically for persons with multimorbidity. Their effectiveness in primary healthcare is well documented. Currently, none of these interventions have synthesized a patient-centered care approach for care for multimorbidity. The objective of this project is to determine the particular elements of patient-centered interventions and interventions for persons with multimorbidity that are associated with positive health-related outcomes for patients.

**METHOD:** A scoping review was conducted as the method supports the rapid mapping of the key concepts underpinning a research area and the main sources and types of evidence available. A five-stage approach was adopted: (1) identifying the research question; (2) identifying relevant studies; (3) selecting studies; (4) charting the data; and (5) collating, summarizing and reporting results. We searched for interventions for persons with multimorbidity or patient-centered care in primary care. Relevant studies were identified in four systematic reviews (Smith et al. (2012;2016), De Bruin et al. (2012), and Dwamena et al. (2012)). Inductive analysis was performed.

**RESULTS:** Four systematic reviews and 98 original studies were reviewed and analysed. Elements of interventions can be grouped into three main types and clustered into seven categories of interventions: 1) Supporting decision process and evidence-based practice; 2) Providing patient-centered approaches; 3) Supporting patient self-management; 4) Providing case/care management; 5) Enhancing interdisciplinary team approach; 6) Developing training for healthcare providers; and 7) Integrating information technology. Providing patient-oriented approaches, self-management support interventions and developing training for healthcare providers were the

most frequent categories of interventions with the potential to result in positive impact for patients with chronic diseases.

**CONCLUSION:** This scoping review provides evidence for the adaptation of patient-centered interventions for patients with multimorbidity. Findings from this scoping review will inform the development of a toolkit to assist chronic disease prevention and management programs in reorienting patient care.

**COMMENT (NPW):** From the perspective of our CHW discussion, the complexity of modern healthcare and increasing levels of multimorbidity in LMICs provide a further rationale for integrating CHWs into the health system as the first level of care, with referral to higher levels in the system as needed. Of course, this implies adequate knowledge of co-morbidities among CHWs as well as integrity of the system as a whole to deal with cases requiring higher levels of care.

Best wishes, Neil

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (111) Family physicians

1 July, 2019

Thanks Neil for the active consultation on CHWs.

I do wonder where is the equivalent discussion, given the very welcome new attention to primary care and the value of CHWs, to family physicians and diagnosticians?

For example I did a quick word search on Perry's papers and the word "diagnosis" appears just 3 times in all the papers. But when communities are dealing with NCDs as well as infection, diagnosis is really important, and needs trained professionals. Then treatment can follow protocols. This rapid response from Donald Li is

relevant. <https://www.bmj.com/content/365/bmj.l2391/rapid-responses> [\*see note below]

What are colleagues expecting in terms of responsibilities for diagnosis in LMICs, particularly given likelihood and complexity of multiple morbidity? Secondly, what about responsibility for communicating the diagnosis, which is a major challenge, particularly for NCDs regarding longterm care, behaviour change and maybe treatment.

Thanks

Siân

HIFA profile: Sian Williams is Executive Officer at the International Primary Care Respiratory Group in the UK. Professional interests: Implementation science, NCDs, primary care, respiratory health, education, evaluation, value, breaking down silos. sian.health AT gmail.com

[\*Note from HIFA moderator (Neil PW): For the benefit of those who may not have immediate web access, here are the opening paragraphs:

Re: Primary healthcare is cornerstone of universal health coverage

'With reference to the editorial "Primary health care is cornerstone of Universal Health Coverage" published in the BMJ of 3rd June 2019 [<https://www.bmj.com/content/365/bmj.l2391>]...

We completely support the position that primary health care (PHC) is THE cornerstone of universal health coverage (UHC). PHC is the most effective and inclusive means to deliver health services and certainly does need wise investment. Current PHC systems are indeed inflexible and without resources to address social determinants of health. There is a need to re-invent primary care such that communities are at the centre of healthcare. We are convinced that community health workers (CHWs) are an essential part of the PHC team.

However, the statement on Rwanda that 'stand-alone' community health workers (CHWs) acting as "the functional link between communities and health care facilities, SUCH AS HOSPITALS" is expected to provide sustainable UHC disturbs us. The editorial does not mention that good quality primary care for patients before they reach hospitals is more cost-effective and that PHC is essentially a team approach...']

## CHWs (112) Certification of CHWs (6)

1 July, 2019

Recommendation 5: Using competency-based formal certification for CHWs who have successfully completed pre-service training.

Certification is important to formalizing the CHW profession, raising CHWs profile/perceptions of legitimacy among other healthcare workers and providing them a foundation for career advancement. Yet setting up credentialing systems can be tricky; effective formal certification requires management and tracking systems. In the US, states have grappled with how to credential CHWs, what it means for sustaining the profession, and the challenges it presents to maintaining some of the best qualified CHWs - who may not speak English fluently or have high levels of education - in the profession. While the US is a high income country, we face huge barriers to health access for poor and underserved populations and many of the issues states are grappling with and the lessons they have learned will resonate with people in low- and middle-income countries.

For those interested in reading more on CHW certification, try this CHW Central link to see what is currently available: <https://www.chwcentral.org/search/node/Certification>

To read more about state approaches to certification and CHW leadership in certification processes in the US try:

<https://www.chwcentral.org/community-health-worker-chw-certification-and...>

<https://www.chwcentral.org/how-chw-leadership-strengthens-certification-...>

<https://www.chwcentral.org/community-health-worker-credentialing-state-a...>

I hope these are helpful and informative.

Best regards,

Becky

Rebecca Furth  
Senior Technical Advisor

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[www.initiativesinc.com](http://www.initiativesinc.com)  
[www.chwcentral.org](http://www.chwcentral.org)

HIFA profile: Rebecca Furth is a public health specialist and cultural anthropologist. She is a Senior Technical Advisor at Initiatives Inc., USA and Technical Manager for [www.CHWCentral.org](http://www.CHWCentral.org). Her professional interests include human resources for health, community health worker program strengthening, organizational development, health systems strengthening, and culture and development. She is a member of the HIFA working group on CHWs. <http://www.hifa.org/support/members/rebecca-0> rfurth AT initiativesinc.com

## CHWs (113) Family physicians (2)

2 July, 2019

Dear Sian, really thanks for your letter.

Diagnosis: the cornerstone of medicine.

As you said therapy will follow guidelines available.

Diagnosis must be written down in the health book which stays in the hands of the patient. So simple... so impossible to obtain.

CHWs will never be able to make right diagnose, unless they study medicine in university. The formal cadres in health-care, those in white uniform that work in rural dispensaries (and feel abandoned!!) can make diagnose. They must be regularly refreshed, motivated, supported(!).

They, They and not the CHWs are the health providers recognized by the community.

Unfortunately emphasis today is on CHWs, despite the fact that majority of governments in poor countries have no money neither intention to recruit them.

Greetings from Dodoma

Massimo (Serventi)

Pediatrician

HIFA profile: Massimo Serventi is a long-standing Pediatrician working in Africa since 1982. He currently works on a volunteer basis in an excellent missionary/credited hospital in north Uganda, St. Mary's Hospital-Lacor-GULU. He has worked for several NGOs in 6 African/2 Asian countries. His interests include clinical and community pediatrics, adherence to clinical guidelines and school education as the major determinant of good health. massimoser20 AT gmail.com

## CHWs (114) Family physicians (3) Telemedicine

2 July, 2019

Dear Dr Servanti, and colleagues,

[www.swinfencharitabletrust.org](http://www.swinfencharitabletrust.org)

Please look at our website. We have been supplying doctors working in the developing world with poor, sick, and disabled people, telemedicine links free of charge for over 20 years. 78 countries, hundreds of doctors and nurses benefit from the expert medical advice offered by our volunteer consultants on diagnosis and treatment.

We would be delighted if you would like to join as a referrer from whichever country you happen to be in.

Lord and Lady Swinfen

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## CHWs (116) Certification of CHWs (7) Certification of CHWs in Nigeria

2 July, 2019

It feels good to be in week 5 already.

As stated already during this discussion, Nigeria already practices competency based certification in the pre service training arena for CHWs/CHPs. What is left is to ensure regular and timely updating of the criteria to meet current best educational/ training practices.

Nigeria has already made an excellent head-start in embracing, integrating and motivating community health practitioners within its health system, especially as the practice mostly aligns with the WHO guideline under discussion. What remain for Nigeria is to adapt regularly and as frequently as necessary to keep pace with best evidence and best practice. Nigeria needs to expand the cadre of CHW to embrace others e.g. Traditional Birth Attendants for the many advantages mentioned already on this forum, provided the expansion is grounded on best practice ethos. Afae guards such as supervision, monitoring and evaluation of the whole structure is essential for success. But failure to adapt and improve consistently, leads to ossification and death of policy and practice.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

<http://www.hifa.org/support/members/joseph-0>

<http://www.hifa.org/people/steering-group>

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## CHWs (117) Family physicians (4)

3 July, 2019

Thanks Massimo!

In days of obvious infection and no time for anything else, a simple approach might work but in the world of SDGs, it's complex.

Let us take breathlessness as a symptom.....it takes a lot of time and competence to understand the impact on the person, potential causes and negotiate an acceptable and feasible treatment plan including non-drug interventions.

This is partly what PACK is trying to do - take a symptom-based approach and identify who can do what, I think?

The danger of discussing one cadre of health workers in isolation somehow suggests they can do most things. As Neil mentioned in an earlier posting, there's a whole Rehab debate separate to this CHW one which talks about community-based rehab workers.

Are these a different cadre? You still need trained professionals assessing and tailoring a programme (eg pulmonary rehab, which, incidentally, Neil, is missing from the recent WHO Rehab Factsheet, as is breathing as one of the listed functions!

Best wishes

Siân

HIFA profile: Sian Williams is Executive Officer at the International Primary Care Respiratory Group in the UK. Professional interests: Implementation science, NCDs, primary care, respiratory health, education, evaluation, value, breaking down silos. sian.health AT gmail.com

## CHWs (118) Family physicians (5)

3 July, 2019

It is true CHWs will misdiagnosed many many diseases but with simple algorithm and RTF they can diagnose malaria, simple dehydration from diarrhea and recognize certain signs and REFER isn't that what we are trying

to seek from them but most of all CHEWs are there to inform and advise on preventive and primitive health care.

HIFA profile: Toumzghi Sengal is a physician assistant and currently works as editor and free lance consultant in Eritrea and East Africa region.  
toumzghisen11 AT gmail.com skype:toumsen13 He is a HIFA Country Representative

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## CHWs (119) Certification of CHWs (9) CHWs in Nigeria (2)

3 July, 2019

I think the Nigerian model is well developed. Prof. Joseph Ana is right about adaptation over time to make the scaled up CHW Initiatives successful and relevant to the community as well as the primary health settings they are meant for.

I also think that countries can learn from existing models and develop eclectic models with some common elements.

Thanks and regards,

Sunanda

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

<http://www.hifa.org/projects/community-health-workers>

<http://www.hifa.org/support/members/sunanda>

write2sunanda AT gmail.com

## CHWs (120) Model for CHW training

3 July, 2019

A model of providing continued education for CHWs in South Africa may be of interest to HIFA members. South Africa has a district health system for providing primary care. This includes district/ward based outreach teams made up of a profession nurse and 5 CHWs. Short courses for CHWs addressing topics such as Mother and Child Health have been developed using the innovative, self-directed education method devised for distance learning by nurses, midwives, medical and nursing students, and doctors. This method of group learning by health professionals has been used very successfully and well documented over the past 25 years. The courses are available as books or can be accessed on an open-source learning station using smart phones or personal computers (<https://bettercare.co.za/learn>).

Recently this method has been adapted for CHW who meet with their lead professional nurse on a weekly basis to read the material together and then discuss, in their home language, what has been studied. An unpublished study with CHWs shows that this method is well accepted and improves confidence, knowledge and understanding. The lead nurse facilitates the process but does not teach the CHWs. No formal trainers are needed and therefore the cost of training is minimal. The range of CHW courses is slowly being expanded to cover all important topics such as immunisation. Within a district health model thousands of CHWs can be supported with continuing education without the need for additional resources.

Regards, Dave Woods

HIFA profile: Dave Woods is emeritus professor in neonatal medicine at the School of Child and Adolescent Health, University of Cape Town, South Africa. He is Chairman of the Perinatal Education Trust and Eduhealthcare, both not-for-profit non-government organisations that develop appropriate self-help distance learning material for doctors and nurses who care for pregnant women and their children in under-resourced communities. He has 30 years experience as a clinical neonatologist, with particular interests in perinatal care and training of health professionals. He is currently

developing paper-based continuing learning material in maternal care, newborn care, childhealth, and care of adults and children with HIV/AIDS. He is also participating in the design and development of wind-up appropriate health technology for poor countries. [www.pepcourse.co.za](http://www.pepcourse.co.za) pepcourse AT mweb.co.za

## CHWs (121) Family physicians (6)

3 July, 2019

Dear Hifa members,

Sian's posting and her line of thoughts on the roles of CHWs should be taken seriously. I do not mean going backwards because a lot of progressive ideas have been discussed and double checked and lessons learnt from successful stories. But the Professional caution from Sian is critical in that the anatomy of a human being is a complex one, that is why it takes several years for someone to be trained, working dummies, internship under strict mentorship by qualified doctors. I am not suggesting that these cadres are assuming the role of trained professionals NO! Because medicine is a refined art at the same time health is too important to be left in the hands of doctors alone. However, taking a simplistic approach may impact negatively on what has been achieved but at the same time I wish to appreciate what Neil and his team are doing communicating WHO guidelines and the valuable contributions from experts. My proposal therefore is that retired health personnel should be taking a leading role in working very closely with this group of cadres otherwise we are all together, UHC is the rationale behind all these strategies.

HIFA profile: Kenneth L Chanda is Associate Consultant and Lecturer at National Institute of Public Administration where he is lecturing in Records Management. He is co-author of The development of telehealth as a strategy to improve health care services in Zambia. Kenneth L. Chanda & Jean G. Shaw. Health Information & Libraries Journal. Volume 27, Issue 2, pages 133-139, June 2010. He recently retired as Assistant Medical Librarian at the University of Zambia. klchanda AT gmail.com

## CHWs (122) Reflections on CHW Discussion Week 3 (2)

3 July, 2019

Greetings to all!

It has been one of those better months with all the interactions on CHWs. Thanks to all, I have learned a lot, reflected a lot and have completed a lot

of circles and now looking at many things in a new light. What I realized is that I have not stress as much as I think and believe, the importance of having CHWs program linked to the national health system and the importance of working “WITH” communities using a health system strengthening (HSS) approach for effective implementation that will not only improve health but transformed communities and nations.

I know we all know the WHO six building blocks [\*see note below], however a few years ago, I was introduced to the adapted one by Jhpiego in its Malaria Program. That approach contains an additional 3 blocks - 7. Policy issues (everything to do with policy including, formation, revision, monitoring, implementation, etc.) 8. M&E (looking at what is called (MERL) monitoring, evaluation research and learning) and 9. Community (everything connected with community, including services, providers, approaches). I found that to be very effective and applies that as my HSS approach with 9 instead of 6 blocks in every think I do, even though many always says they are included with the others (blocks 1-6). However, to me they are so essential to transformation that they need to be emphasize as separate building blocks. I am recommending that adaption to you as you look at your CHW programs and you can place them in a checklist and see what you are doing about each and how well and get the “so what” before you move on addressing gaps/challenges and celebrating successes in our work of looking at PHC for UHC.

Peace, Marion

HIFA profile: Marion Subah works for JHPIEGO in Liberia. Marion.Subah AT jhpiego.org

[\*Note from HIFA moderator (Neil PW): The six building blocks are:

- 1: health service delivery
- 2: health workforce
- 3: health information systems
- 4: access to essential medicines
- 5: health systems financing
- 6: leadership and governance

<https://www.who.int/healthinfo/systems/monitoring/en/> ]

## CHWs (123) CHWs in Nigeria (3)

3 July, 2019

I must thank Dr. Joseph Ana for these positive responses about CHEW certification in Nigeria. Sorry, I have not been able to respond for a while, I was preparing, writing my exams with LUTH.

CHEW in Nigeria is Community Health Extension Workers, the word 'Extension' means they have a wide range areas touching health to cover, and that what we have been doing, including Intersectoral collaboration with different ministries, agencies, communities, organizations to ensure health for all.

CHEWs in Nigeria have gone beyond, the bulk of services to the hard to reach areas, the neglected, the forgotten, about 75% of the rural population in Nigeria is served by the CHEWs.

Recently, credence to their skills came to fore leading to stakeholders coming together to assign more task to the under the title - Task Shifting, Task Sharing. I want to thank HIFA, Dr. Joseph and many other contributors for the interest, keep encouraging the positive aspect and let's work together to ammend any needing areas.

CHEWs are expected to supervise, train and monitor the activities of VHW, TBA and others. They spend 40% of their time in the clinic and 60% in the community doing home visit, referrals and other integrated services.

CHEWs has the slogan of 'Community Health - Our Concern'.

HIFA profile: Owolabi Sunday Adebayo is a Health Officer (CHW) with special interest in Herbal medicine at Ilera Eda Herbal World in Nigeria. Professional interests: Trained Community Health Extension Worker, has cert in Health Administration and Mgt and a Bsc in Health Edu. Professional interest in Traditional medicine. I operate a traditional medicine center, produce Herbal medicine.... currently treating patients with High blood pressure, stroke and breast cancer. Email address: oasisofcreative AT yahoo.com

## CHWs (124) Family physicians (7) PACK (Practical Approach to Care Kit) (5)

3 July, 2019

Sian, you are right PACK (Practical Approach to Care Kit) tries to mimic how patients present to the clinic and the subsequent practitioner-patient interaction, which is why it is symptom based (patient presentation) and algorithm navigation (to arrive at differential diagnosis of the patient in front of the practitioner). In Nigeria for instance it has brought all the cadres into interaction and cooperation (JCHEWs, CHEWs, CHO, Nurses, Midwives, Doctors) using one Guide (unlike when every cadre had their own distinct guide separate from the other cadres).

One spin off in Nigeria is that where PACK Nigeria is in use there is multidisciplinary team working in harmony, respect for what each cadre brings to quality care and appropriate and timely referral after necessary stabilization of the patient, knowing cadre limits based on their curriculum of training and policy documents.

Inter professional disharmony in the health system in Nigeria is such a huge problem and it hinders health system strengthening and quality care, that there has been at least three Presidential Committees by the Federal Government on the problem, seeking solution. PACK Nigeria by making all cadres work together seamlessly provides a veritable way to integrate care amongst cadres, harmoniously.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

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## CHWs (125) Certification of CHWs (10)

4 July, 2019

Hi Daniel, [in response to Daniel Stern:

Tanzania/Uganda: <http://www.hifa.org/dgroups-rss/chws-114-certification-chws-7>]

I couldn't agree with you more. I have seen CHWs with little education in India, Tanzania and Zambia learn skills and provide excellent quality services. I think the question is not can CHWs, with variable levels of education, be trained and perform, but how do we maintain the dynamism and diversity of CHWs as programs formalize? For example, in creating national salaried cadres of CHWs, countries such as Tanzania, Zambia and others have found that to be paid through the civil service, CHWs have to meet civil service education requirements (frequently grade 10, 12 and a certain number of O levels) and this leaves out many of the existing CHWs trained to provide MNCH, HIV or other services. The same is true in the US, as states move to create formal certification programs, they grapple with how to ensure that valuable and existing trained workers are not "left behind" because they do not meet newly established criteria for certification. Many states have dealt with this by putting in place systems to "grandfather" in existing workers, enabling them to become certified by taking into account experience over certain minimum education requirements, for example, while simultaneously establishing new education and training requirements for new CHWs.

Becky

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HIFA profile: Rebecca Furth is a public health specialist and cultural anthropologist. She is a Senior Technical Advisor at Initiatives Inc., USA and Technical Manager for [www.CHWCentral.org](http://www.CHWCentral.org). Her professional interests include human resources for health, community health worker program

strengthening, organizational development, health systems strengthening, and culture and development. She is a member of the HIFA working group on CHWs. <http://www.hifa.org/support/members/rebecca-0> rfurth AT initiativesinc.com

## CHWs (126) Certification of CHWs (11) New message from Daniel Stern, Tanzania/Uganda

5 July, 2019

[Note from HIFA moderator (NPW): I am forwarding this on behalf of Daniel Stern, Tanzania/Uganda]

Dear Becky, thank you; seems you have hit the nail on the head; how do we maintain the dynamism and diversity of CHWs as programs formalize?

I believe there is a trade-off, i.e. the illiterate CHW whose extraordinary healthcare skills to a great extent depend upon her ability, as an illiterate person, affords him or her to enter other worlds, seamlessly, and would be in danger of losing this magnificent facility, were required literacy foisted upon them in an unnatural way. I had the pleasure of hosting a leader of the Ik people at my home in Kampala. The Ik are hunter gatherers in the extreme north east of Uganda. His people are illiterate, yet he had university degrees that enabled him to deal with government officials such that his people would not be unnecessarily abused, even by well meaning government. And yet he could still move comfortably between the two or more worlds he lived in. I believe we must be more sensitive in respecting the spiritual side of healing. If you will read Harvard's Dr. Atul Gawande' book, Complications about his surgical residency he touches on this subject delicately, in the last chapter, The Red Leg. The Ugandan traditional midwives I spent time with would deliver breach births effortlessly, without an ultrasound, for they SEE, by virtue of their spiritual gifts.

Dr. Joseph Ana recently mentioned in this same forum how "inter professional disharmony (which seems to be an oxymoron) was a huge problem that undermined the strengthening of quality care, which I would suggest was part of the downside of literacy.

Thanks again, and best wishes, Daniel

HIFA profile: Daniel Stern is a HIFA Representative and member of the mHIFA WG. He is a member of Uganda MCH TWG. Daniel is Co-founder of the educational NGO Uconnect, and of the Innovation Hub, Hive Colab, and is also Cofounder of ISOC Uganda and Uganda IXP. He is a UN WSA National

Expert. His Uconnect team distributes off-line E-Learning content, including Hesperian Health Guides to schools in East Africa since 2008. During his six-years as Lead for Uganda Mobile Monday he regularly organized events with mobile health themes, usually in collaboration with UNICEF's Uganda team, and their pan African IntraHealth efforts to improve interoperative healthcare systems, both within and between countries, in mHero, such that developer- entrepreneurs's apps would align with the latest trends by MoH policies. <http://www.hifa.org/support/members/daniel>

DStern AT Uconnect.org

## CHWs (127) Certification of CHWs (12)

5 July, 2019

Dear Becky,

You are spot on, and the situation is not any different in Uganda where CHWs with low levels of education make a contribution in improving health in their communities. Whereas certification of CHWs requiring high levels of education is welcome, we need not forget those who may not meet the requirements yet have a wealth of knowledge and experience in offering primary health care and public health services in their communities.

Best wishes,

David

HIFA profile: David Musoke is a Lecturer at the Makerere University School of Public Health, Uganda. Professional interests: Malaria prevention, community health workers, environmental health, public health, disadvantaged populations. He is a member of the HIFA working group on CHWs. [www.hifa.org/projects/community-health-workers](http://www.hifa.org/projects/community-health-workers)  
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## CHWs (128) Certification of CHWs (13) New message from Daniel Stern, Tanzania/Uganda (2)

5 July, 2019

Daniel Stern has delightfully covered some interesting themes in his posting: 'Illiterate CHW and their entrance into a different world'; 'Traditional Birth Attendants (TBAs) practicing advanced skills like breech delivery without US

Scans'; 'spiritual side of healing'; 'inter professional disharmony and its negative effect on health system strengthening'.

All of which could actually form the basis for deeper discussions and analysis.

For instance more light could have been thrown on how illiterate CHW get to learn the basic knowledge that underpinned the health information that they pass on to the community in their health promotion and prevention roles and if they have to engage in even the most basic treatment roles how do they learn the necessary skills. How would illiterate persons who want to be CHW enter the world that WHO guideline describes: selection, training, certification, practice, etc.

It is very interesting to read that TBAs deliver complex presentations like breech during childbirth without equipment aids. Before US Scan was discovered in health practice, skilled personnel conducted such deliveries, following training and apprenticeship. How do the TBAs learn to do it? And what is their success rate or failure rate?

A very close relative of mine recently pursued the theme of spirituality and healing to a University Masters degree and came up tops with MA (distinction), so it is increasingly an important topic to be on the front burner, especially given the challenges that arise in health and medical practice in a world that is struggling with spiritualism, religion and a spectrum of atheism and Big Bang theory.

It would be nice to hear members comment on inter professional disharmony, which as I said forms a huge spanner that is hindering efforts to strengthen the health system in Nigeria. Does it exist in other countries, what are the causes and effects, and what is being done to stamp it out / control it?

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took

the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

<http://www.hifa.org/support/members/joseph-0>

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## CHWs (129) Compilation of messages during week 4

5 July, 2019

Dear HIFA colleagues,

Thank you once again for all your valuable contributions to this discussion so far!

Please find here a compilation of messages during week 4 (21-28 June 2019), with thanks to HIFA volunteer Sam Pakenham-Walsh:

[http://www.hifa.org/sites/default/files/articles/CHW\\_discussion1\\_compila...](http://www.hifa.org/sites/default/files/articles/CHW_discussion1_compila...)

We hope you find this useful to review and contribute to the ongoing discussion.

Background to the discussion, questions and all compilations are available here:

<http://www.hifa.org/news/who-hsg-hifa-collaboration-empowering-community...>

(scroll down to see the PDF links)

To contribute to the discussion, please send an email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

We welcome any message that relates to CHWs, at any time. We are carefully documenting and collating all the key points and these will help inform future action.

With thanks, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: [www.hifa.org](http://www.hifa.org)

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (130) What can Herbal or Traditional medicine treat?

5 July, 2019

From now I will be addressing issues concerning Traditional medicine practice.

I think it will be too elementary going back to defining traditional medicine this time around, over the years WHO has provided us with distinctive definition and definition for its practitioners. So for this report I want to address the above questions.

Herbal medicine can treat almost any condition that patients might take to their doctor. Qualify herbalists know when a condition is best seen by a doctor or another therapist.

Nobody is an island of knowledge, herbalists and other traditional medical practitioners do not relegate, discriminate other knowledge, idea or skill no matter how little or crude it may seem. Herbalist believes, and holds knowledge possess by other people in high esteem. The Yoruba language for medicine is a prove to this 'Oogun' - something extended, without end, or infinity. They even went ahead to propound that "where someone else

knowledge about it stops, there begins another person" ibi ti teni kan pari si ibe ni ti elomiran ti bere. Eni to mo eyi ko mo eyi.

I recollect my father of blessed memory told me he had to trek 9 or more miles away to meet people whom he heard possess a type of document, skill or knowledge for a particular medication of a disease. He would go to them, exchange pleasantries, and been a staunch practitioner, they would exchange ideas.

Nature has provided us with all the solutions to our problems, we only need to look in more deeply to discover surrounding values, those values that are very essential for human health.

"Medical herbalists are trained in the same diagnostic skills as orthodox doctors but take a more holistic approach to illness. The underlying cause of the problem is sought and once identified, it is this which is treated, rather than the symptoms alone. The reason for this is that treatment or suppression of symptoms will not rid the body of the disease itself. Herbalist use their remedies to restore the balance of the body thus enabling it to mobilize its own healing power.

Many of the pharmaceutical drugs used today are based on plants constituents and, even now, when scientists are seeking new 'cures' for disease it is to the plant world that they turn. They find, extract and then synthesise in the laboratory a single active constituent from the plant (the active constituent is the part of the plant that has a therapeutic value), this can then be manufactured on a large scale.

However, people have always relied on plants for food to nourish and sustain the body. Herbal medicine can be seen in the same way. Plants with a particular affinity for certain organs or systems of the body are used to feed and restore to health those parts which have become weakened. As the body is strengthened so is its power and ability to fight off disease and when balance and harmony are restored, health will be regained.

Herbalists believe that the active constituents are balanced within the plant and are made more or less powerful by the numerous other substances present. It will be difficult to analyse completely the whole chemical constituent especially when dealing with natural healing, still lies hidden secret that only nature understands how it works. Herbal drugs, however are extracts from a part of the whole plant e.g leaves, roots, etc and contains hundreds, perhaps thousands of plant constituents". Journal of Christian CAM practitioners. UK

What really works in herbs are in the originality of it being natural. Psalm 104 vs 14 - And HERBS for the services of man. Nature has granted all our body required for its services and for better functioning, for the correction of every malfunctioning and management of it. The secret of the elements that works is limited to the scientific analysis. The mystery is in the WORD spoken by the nature that created them. The WORD will never end, it is eternity, and that is God. Science may believe in what they see and can analyse but still what is essential is invisible to the eye. Thunder don't just strike, a force controls it, forces scientific can not see.

Like attracts likes, iron sharpens iron, so is human and other natural gift, they can only complement each other. The word of Hippocratic still relevant - let your food be your medicine and your medicine your food. Vegetables, fruits, fish, eggs, palm oil, okra, water are the medicine for hunger, once you refuse to take them your body becomes restless, headache set in, loss of sleep, isolation with social well-being, because you nag often, but once, they are taking body becomes active then they are medicine. Once food is not taking in the correct proportion diseases set in, not blood tonic or chemotherapy is capable of restoring health, but adequate diet which are composed of HERBS, what are these herbs? Vegetables, melon, pepper, palm oil water. Humans are made from soil, so does vegetables originated from soil, they have affinity for each other and they are made to solve each others problems. Another fact is that, the vegetables, fruits, cereal and other food items when they are grown and ripe they are in problems if they are not eaten, eaten by man, they rotten and fails to fulfill the essence of creation, human being is their solution to their problems, to eat them as at when due, same goes for men who must eat them as food as medicine for man to fulfill the essence of its creation. It is the secret of the nature.

It is quite conceivable that some alternative medicine practitioners are using useful compounds or techniques which are not yet known to Orthodox medicine, researchers and those who make derogatory remarks. This is the skill, this is the secret of our fathers, Ohun ti agbalagba fi n jeko abe ewe lowa - the secret of the survival of our fathers remains sacred. You can not discover this, unless a reasonable provision is made for this practitioners to live a meaningful life like a Nigerian citizens.

No traditional medical practitioner set out to have products to kill, damage the health of his or her clients. But because the Nigerian system of health in the hands of 'acclaimed' Alfa and omega, they labelled the traditional medicine practice with all negatives. Sugbon nitori a ti pa Aja a n soo ni oruko buruku.

Thanks.

HIFA profile: Owolabi Sunday Adebayo is a Health Officer (CHW) with special interest in Herbal medicine at Ilera Eda Herbal World in Nigeria. Professional interests: Trained Community Health Extension Worker, has cert in Health Administration and Mgt and a Bsc in Health Edu. Professional interest in Traditional medicine. I operate a traditional medicine center, produce Herbal medicine.... currently treating patients with High blood pressure, stroke and breast cancer. Email address: oasisofcreative AT yahoo.com

## CHWs (131) Introduction: Faith Atai, Uganda

6 July, 2019

My name is Faith Atai. I work as a health inspector at Soroti Municipal Council, Uganda. Currently, am a student at Makerere

University School of Public Health pursuing a bachelors degree in environmental health science. I have directly worked with communities for five years and it's been amazing. While at work, I take part in the implementation of community based public health interventions and also conduct pieces of training of grass root community health workers. The experience overall is thrilling to me because it's a profession I chose to take such that I can make a positive contribution to the communities.

HIFA profile: Faith Atai is a Health Inspector at Soroti Municipality in Uganda. Professional interests: Working with grass root community health workers to protect, preserve and promote health. Email address: ataifaith AT @gmail.com

## CHWs (132) Compilation of messages during week 5

6 July, 2019

Dear HIFA colleagues,

Thank you for your contributions to the discussion so far. We are now entering our sixth and final week.

Please find here a compilation of messages during week 5 (27 June to 4 July 2019), with thanks to HIFA volunteer Sam Pakenham-Walsh [<http://www.hifa.org/support/members/sam>]:

[http://www.hifa.org/sites/default/files/articles/CHW\\_discussion1\\_compila...](http://www.hifa.org/sites/default/files/articles/CHW_discussion1_compila...)

We hope you find this useful to review and contribute to the ongoing discussion.

Background to the discussion, questions and all compilations are available here:

<http://www.hifa.org/news/who-hsg-hifa-collaboration-empowering-community...>

(scroll down to see the PDF links)

To contribute to the discussion, please send an email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

We welcome any message that relates to CHWs, at any time. We are carefully documenting and collating all the key points and these will help inform future action.

With thanks, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: [www.hifa.org](http://www.hifa.org)

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

[CHWs \(133\)](#) [Certification of CHWs \(14\)](#) [Training traditional birth attendants in Nigeria \(11\)](#)

6 July, 2019

Dear Dr. Joseph, Thank you for the corroboration, and additional guidance. [\[http://www.hifa.org/dgroups-rss/chws-128-certification-chws-13-new-messa...](http://www.hifa.org/dgroups-rss/chws-128-certification-chws-13-new-messa...)

Prof. Gawande gave the Reith Lectures in 2014 on the theme, The Future of Medicine. Btw, ""traditional Midwives" is the preferred term for these heroic women, whose healthcare skill sets boggle the mind, and who should be recognized globally by healthcare institutions, including UN Agencies, before we have any chance of putting things in proper perspective to the end the neglect of these often despised CHWs that they may enjoy greater self esteem and be enabled to show the formally educated healthcare professionals how they have managed to stand in the gap, despite persecution by their formally trained colleagues.

Through simple measures, love, honesty, humility, one male obstetrician transformed the ambiance of the referral hospital in Karamoja by making patients and their friends and relatives and children who now feel comfortable when visiting the ANC clinics, due to aligning their methods in maternal and infant healthcare to conform to the local cultures and traditions. And thus ANC stats shot up, with no additional burden to the existent budget. No more abusive certified midwives under this doctor's watch!

And "Obedience commands obedience". That, BTW is how leadership is born.

When I read your response to my earlier post, I was reminded of one of our monthly MCH TWG meetings, under the auspices of this East African country's MoH

First Friday of every month, from 9 AM to 1 PM, beautifully brutally truthful - no BS allowed!

The formidable Chair or , moderator kept us on our toes, and it was extremely intense, like a war room; Each of us dedicated defenders of the faith to do the needful to minimize maternal and infant morbidity and mortality, acutely aware, at some deep level of our being, that the pain, the suffering might be lessened by our concerted efforts.

The moderator Th at this meeting was a highly competent compassionate and respected medical doctor as well as high official of the ministry.

During one of the mornings presentation by one of the larger healthcare NGOs our chair interrupted her presentation after she quoted one of the

official statistics for the percentage of babies born outside of the healthcare system, to remind us that we all knew that the true percentage was probably quite higher. Some whispered that it might be as high as three times as high

This man's honesty, courage and integrity, leading by example put wind in our sails, encouraging us to stay true to the great cause to which we had dedicated ourselves.

In closing, we need to think about the un-remembered and often despised traditional midwives who probably still play a key role in the safe delivery of as much as two thirds of babies born outside the healthcare system, - a system that has for too long neglected to provide sufficient support in proportion to the CHW's contribution to country's primary healthcare needs.

Let's see what we can do advocate for rectifying this negligence, and put things right.

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HIFA profile: Daniel Stern is a HIFA Representative and member of the mHIFA WG. He is a member of Uganda MCH TWG. Daniel is Co-founder of the educational NGO Uconnect, and of the Innovation Hub, Hive Colab, and is also Cofounder of ISOC Uganda and Uganda IXP. He is a UN WSA National Expert. His Uconnect team distributes off-line E-Learning content, including Hesperian Health Guides to schools in East Africa since 2008. During his six-years as Lead for Uganda Mobile Monday he regularly organized events with mobile health themes, usually in collaboration with UNICEF's Uganda team, and their pan African IntraHealth efforts to improve interoperative healthcare systems, both within and between countries, in mHero, such that developer- entrepreneurs's apps would align with the latest trends by MoH policies.

<http://www.hifa.org/support/members/daniel>

DStern AT Uconnect.org

## CHWs (134) CHWs and mental health (3) Supervision of CHWs

6 July, 2019

Dear HIFA colleagues,

We have discussed the role of CHWs in providing mental health services. This paper looks specifically at methods of supervision of task-shared mental health care, with a focus on Africa. Citation and selected extracts below.

CITATION: Supervision of Task-Shared Mental Health Care in Low-Resource Settings: A Commentary on Programmatic Experience

Christopher G. Kemp, Inge Petersen, Arvin Bhana, Deepa Rao

Global Health: Science and Practice, 2019

<http://www.ghspjournal.org/content/7/2/150>

'Task-shared mental health care programs in low-resource settings often incorporate supervisory structures that would be difficult to implement at scale, and many rely on foreign specialist experts as supervisors. Future programs could leverage peer supervision, technology, competency assessments/fidelity checklists, and other tools. Mental health care specialists will require training, support, and incentives to supervise generalist care providers.'

'The relative effectiveness of different supervisory models for task-shared mental health services in low-resource settings remains understudied, although recent calls for research suggest that a change is imminent. Little is known about the range of supervisory models already developed and implemented as part of task-shared mental health care in low-resource settings. An exploration of these models would offer support to future programs as staff plan, design, and implement task-shared programs. Our objectives were to provide an overview of the literature on the supervision of frontline and mental health care workers in low-resource settings, to describe and draw lessons from the experiences of implementers of task-shared mental health services in these settings, and to offer evaluative commentary for consideration by future investigators and implementers.'

### OVERVIEW OF SUPERVISION MODELS

Supervision of frontline health care workers – including but not limited to

those delivering mental health care – may take many forms. Most broadly, supervision refers to the cyclical process in which a senior professional or team sets expectations for the practice of health care workers at a lower level in the health system, observes and/or audits that practice, assesses whether it meets expectations, and provides guidance or takes corrective action.<sup>23</sup> Supervisors employ a wide range of activities to carry out these functions, and health systems may focus on and prioritize some supervisory functions over others. Depending on that focus, models for supervision fall along a spectrum of 3 general categories: traditional supervision, supportive supervision, or mentorship...

One well-documented approach to task-shared mental health supervision—focused specifically on psychosocial treatments—is the apprenticeship model: a collection of training and layered supervision methods originating with researchers at Johns Hopkins University, named after the model used by many crafts and trades. It is distinguished by its inclusion of 3 types of individuals: counselors, supervisors, and trainers.<sup>47</sup> Counselors may be any type of mental health service provider, including community members trained to deliver a psychosocial intervention, while supervisors are counselors with the expertise or skills necessary to support other counselors...

We interviewed 16 informants between October 2015 and January 2017. Most were researchers, and most worked in sub-Saharan Africa... Informant experiences reflected 5 broad themes: movement from research to scale-up; building capacity for supervision by specialists; social hierarchies and supportive supervision; technological opportunities; and allowing for context, fluidity, and heterogeneity. We describe each of these below...

Specialists need additional training in supervision and personnel management to manage teams of task-sharing mental health workers...

## CONCLUSION

Supervision is an understudied but critical component of task-shared mental health programs in low-resource settings. As interventions move from development to implementation and scale-up, models for supervision that are feasible for dissemination are increasingly being developed. In the absence of adequate numbers of specialists to provide supervision, technological solutions like audio recording and WhatsApp groups supported by supervisor guides and fidelity checklists can help promote better quality supervision as well as contact with supervisees. Further research is necessary to evaluate models for supervision across different programs and contexts.

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Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

<http://www.hifa.org/projects/community-health-workers>

Access the CHW Guideline here:

<https://www.who.int/hrh/community/en/>

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: [www.hifa.org](http://www.hifa.org)

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

## CHWs (135) Selection of CHWs for pre-service training (16) CHWs with low literacy

7 July, 2019

[in response to Rebecca Furth, USA: <http://www.hifa.org/dgroups-rss/chws-125-certification-chws-10> ]

This is my greatest challenge, in the renew support for CHWs. It is not only leaving those who were trained before behind but how do we ensure the real full engagement of communities when our selection criteria do not fit those they would like or those in the community do not meet the requirements. This is especially significant considering that the main reason they are not selected is because they do not meet the education requirements. During the days long ago when it was promoted that CHWs should use the five essential drugs to prevent mortality at the community level and when all said CHW needed to be literate so they would not give the wrong medication of the five, the famous Dr. Mrs Arole explain to me in working with illiterate women in the CRHP [\*see note below], that she did not know of anywhere in the world where women use more flavoring and spices, etc. in cooking than India, however the illiterate women as these women she worked with were, they never mixed them up and put the wrong

spices in a dish. This was just like what she had seen in all the many years of working with them. She had not seen these illiterate women given the wrong medicine to any child. Instead with the appropriate training and supervision use by CRHP, these women had even taken what they learned and applied them in such extraordinary ways that proved to be more effective and were making unimaginable progress in improve health and transforming their communities.

That confirm exactly what I had seen and know now from in all these over 30 years. Like I told those in Liberia, we are saying that because we want things to be easy for us. The burden is on us, highly educated and experts to work together, including with those of us in education and training, to come up with creative ways to trained and supervise illiterate CHWs, a means of getting correct and appropriate data and getting them to use their data for decision making as was done by Dr. Mrs Arole and others at Jamkhed, India. I know there are ways, because I have worked with Traditional midwives for over 30 years and have seen what those illiterate women can do that I would not exchange for literate ones because we the experts cannot come up with appropriate methods to teach and supervise them and obtained the right data that can be used to make appropriate decision. So I would like to challenge us not to have literacy as a criteria for exclusion but rather to be creative and come up with appropriate methods of working with them and benefitting from their expertise in community health as we are all teachers and learners as Jane Valla and my peers in “Dialogue Education” would say or be like the US Ambassador to Liberia says and meet these communities where they are and work with them to where they would like to and should be.

HIFA profile: Marion Subah works for JHPIEGO in Liberia. Marion.Subah AT jhpiego.org

[\*Note from HIFA moderator (Neil PW): CRHP = Comprehensive Rural health Project]

CHWs (136) Modalities of pre-service training (4)  
ANCHUL (AnteNatal and Child Health care in Urban sLums) (2)

7 July, 2019

Excellent resources and thanks for sharing [<http://www.hifa.org/dgroups-rss/chws-96-modalities-pre-service-training-....>]. As It is important that we as NGOs work with the MOHs to make sure the Ministries policies and guidelines do not conflict with ours and that we are implementing in

alignment with the MOH, in Liberia we are now working with the MOH on policies and guidelines at what could be consider urban community health promoters and the guidance in the tool kit, especially on selection, training, supervision, etc. is very good as we discuss integration of large scale programs and institutionalization of Programs with paid CHWs according to the WHO recommendations.

In addition, I am doing an online course on Strengthening Community Health Workers Programs through Harvard University led by Dr. Raj Panjabi of Last Mile Health with many excellent co-presenters, that I would like to recommend to all, especially those like me with much community health experience, who in this forum that do not know about it yet.

HIFA profile: Marion Subah works for JHPIEGO in Liberia. Marion.Subah AT jhpiego.org

## CHWs (137) Selection of CHWs for pre-service training (17) CHWs with low literacy (2)

9 July, 2019

Dear All,

Charles Dewah, Marion Subah, Rebecca Furth and a few others have echoed my thoughts about educational qualifications, certification and other aspects of WHO guidelines to formalise the CHWs becoming a part of the mainstream.

I was among those inspired by the work of Aroles and Bangs in rural and tribal areas of India when I was beginning my work in the community to look at Early Childcare and development of children with special needs in the urban slum community. In essence I was trying out something similar, except that the focus was on childhood disability.

Today, after a few years in such settings (resource constrained urban settlements), these are a few of my observations :

1. Communities are not homogeneous. Neither is the nature of community health needs.

2. The factors that influence health in the community are several.

- Often, the determinants at play are not very different from those propounded by Dahlgren-Whitehead. [\*1 see note below]

(Pediatricians may also relate to the Bronfenbrenner model of Child Development [\*2])

3. CHWs, even when residing in the community, have a limited understanding of health care when not a part of the system and require training, a continued guidance and hand holding support in special projects because of their low levels of literacy.

4. The level of native intelligence is high, they learn quickly on the job, are self-motivated to perform with small incentives (which include acknowledgement of their contribution and respect for their work), in addition to a decent remuneration.

It would be a pity to lose the traditional health workers such as the dais or traditional birth attendants (TBA) on the grounds of education level or not having a recognised certificate. Many of them demonstrate a commitment to community service and possess good interpersonal skills. There is a strong need to have modular training to retain them in the System.

5. Changes over time in the world around the CHWs are not to be ignored.

The younger generation of CHWs do care about certification and career prospects.

They adapt to technology well and can perform better under technology-guided supervision. However, they are quick to make career moves in quest of better financial prospects and this results often in poor experiential learning as well as loss to the community.

Acceptance by target Community also takes a while and a public service ethos can be developed only if there are senior professionals working alongside or mentoring the junior cadres.

Personally, I believe that on-the-job training adds value to the work, irrespective of the curriculum of pre-service training.

6. CHWs may be seen as Community Health aides who are a part of the health team in the Primary care setting and not as replacing other health professionals in the Health Centre. While being valuable human resources for health in all Developing countries, they must not be seen as alternative health work force substituting for the Nurses, therapists, and doctors. They must be empowered with skills and knowledge to bridge the divide between marginalized, hard- to- reach Communities and inaccessible Health Centres.

Hence, the training should be appropriate to the tasks under consideration and certification should also reflect the scope of the training.

Lastly, the time is ripe for us to now explore how global health Communities and local CHW communities can work together to better understand the needs and priorities for Primary Health care in the context of Universal Health Coverage. This may mean prioritising prevention, health promotion, rehabilitation and palliative care as prime areas for CHWs, while encouraging them to play assistive roles for diagnostic and curative services as per the demands in the particular setting.

Thank you.

Best regards,

Sunanda

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

<http://www.hifa.org/projects/community-health-workers>

<http://www.hifa.org/support/members/sunanda>

write2sunanda AT gmail.com

[\*Note from HIFA moderator (Neil PW):

1. The Dahlgren-Whitehead rainbow model of socialdeterminants is described here:

<https://esrc.ukri.org/about-us/50-years-of-esrc/50-achievements/the->

[dahl...](#)

2. The Bronfenbrenner model of Child Development is described here:

<https://www.firstdiscoverers.co.uk/child-development-theories-urie-bronf...>

CHWs (138) Selection of CHWs for pre-service training  
(18) Remuneration of CHWs and other primary health workers

10 July, 2019

[\*Note from HIFA moderator (Neil PW): The message from Massimo below was originally sent off-list and is forwarded with his permission]

Dear Massimo,

You are right [see below] about the need for existing cadres to be remunerated well and taken care of. I am all for it.

It is also true that communities do not pay the salaries to CHW. Often they are paid under projects of non-governmental sector when not part of the Government system.

However, there have been suggestions for village heads to sustain the salaries from the funds allocated to them. We are also advocating for CHWs to form Self helps groups as in Bangla Desh but it may not be easy to sustain in India. ASHAs are there for specific work and many of us have voiced our opinions at various fora that they need to be paid well. It goes without saying that existing cadres at PHCs need to be paid even better. I endorse your view that Health care personnel should all do what they are expected to do, and we should be looking at task sharing and not task shifting.

Let us face it, task shifting is needed only because Health facilities are poorly staffed in the first place. If we need CBR workers in disability related Health Initiatives, it is because of a shortage of rehabilitation professionals; poor urban slum communities cannot afford the costs of transdisciplinary care (early intervention) the children require.

If slim budgets prevent good remuneration for front line workers, will Governments even have the finances to create health infrastructure everywhere to meet the doctor/ nurse- patient ratio better? I believe that it

is not an "EITHER- OR" situation. We need both to achieve UHC. Increasing allocation for health in National budgets is a priority and WHO recommendations, I hope, will serve to strengthen political will.

Thanks and best wishes,

Sunanda

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

<http://www.hifa.org/projects/community-health-workers>

<http://www.hifa.org/support/members/sunanda>

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Dear Sunanda [re: CHWs (137)], you should add to your points the following

CHWs are nowhere recognized/remunerated by their communities (as it should be - my note).

Formal health workers are already trained, are respected by their communities and above all CAN DO AND SHOULD DO THE SAME WORK EXPECTED FROM CHWs(in capital letters!).

Dear friends in the world, when budgets are slim one should concentrate on what is already in place, support-refresh personnel that already is employed and NOT create new cadres that wont be able to sustain on the long run. This is the case of CHWs.

Greetings from Dodoma

Massimo

[HIFA profile: Massimo Serventi is a long-standing Pediatrician working in Africa since 1982. He currently works on a volunteer basis in an excellent missionary/credited hospital in north Uganda, St. Mary's Hospital-Lacor-GULU. He has worked for several NGOs in 6 African/2 Asian countries. His interests include clinical and community pediatrics, adherence to clinical guidelines and school education as the major determinant of good health. massimoser20 AT gmail.com]

## CHWs (139) Introduction: Aparna John, UK/India - Anganwadi workers

10 July, 2019

Dear HIFA community,

I'm a researcher who works on Community Health Workers in India. My PhD focused on the drivers of performance of one of the CHW cadres in India: Anganwadi workers [\*see note below]. I then worked on a FLW grant by Oxford Policy Management, funded by the Gates foundation synthesizing evidence on the performance of FLWs in India.

I'm keen to network with other researchers who are working on CHWs around the world.

<http://www.hifa.org/support/members/aparna>

Many thanks,

Aparna John

HIFA profile: Aparna John is a researcher who works on Community Health Workers in India. Her PhD, which she successfully defended early 2018, focused on the drivers of performance of one of the CHW cadres in India: Anganwadi workers. She later worked on a FLW grant by Oxford Policy Management, funded by the Gates Foundation. She is based in Witney, Oxfordshire, UK and is keen to network with others. She is a member of the HIFA working group on CHWs. john.aparna AT gmail.com

[\*Note from HIFA moderator (Neil PW): 'Anganwadi is a type of rural child care centre in India. They were started by the Indian government in 1975 as

part of the Integrated Child Development Services program to combat child hunger and malnutrition. Anganwadi means "courtyard shelter" in Indian languages. A typical Anganwadi centre provides basic health care in a village...' <https://en.wikipedia.org/wiki/Anganwadi> ]

## CHWs (14) What are your thoughts on the Guideline? (18)

11 July, 2019

Dear HIFA team,

It is with great pleasure I learnt about CHWs empowerment process through initiatives such as WHO training standardization guidelines, as CHWs are key persons in health chain, closest to people & communities.

We just completed second batch training for CHWs part of/serving Garbage city community of Manshiat Nasr, Cairo/Egypt. First batch was trained in 2018. It was a challenging and beautiful project, funded by private donations (individual small contributions).

I am contributing with some comments based on our experience.

As consultant with PCI (Primary Care International), I have submitted some comments to them, so it might come to you from them as well.

Question 1: What are your thoughts on the Guideline? What questions do you have about it?\*

Guidelines well needed as reference to good practice and framework for action. Helps in co-building project with local partners and gives framework for handover.

Lacking aspects of training of trainers, with identifying champions who could receive a specific training added to the standard one, for continuity purposes when there are many stakeholders or when project is funded by external body / organization / trainers who will not be present on site after training completion.

In our project, I have trained 2 doctors (out of 3 in the training team) in project management, training skills, presentation & communication, workshop organizational skills using a large range of participative training techniques. They will be continuing CHW training process in the garbage city community with training other CHWs.

We have also selected 6 CHW from the best trainees (after written & oral assessment based on knowledge and skills) to be running the community center health aspects, and secured some finances for their monthly payment for one year. They will be responsible for delivering health trainings in community and reference for training other CHW.

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Q2. Recommendation 1 suggests certain criteria to use and not to use for selection of CHWs. How do these criteria relate to current practice in your country/experience? Are these criteria implementable in your country/experience?

Literacy level should not be a strict criteria.

We discovered few days before exam session that one of the trainees could not read / write and we had to organize a helping person to sit the exam with her. This CHW attended and participated in every session, was receiving same handout without us noticing she could not read. She passed exam and is an asset to the team.

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Q3. Recommendations 2, 3 and 4 make suggestions on length of pre-service training, competency domains and modalities. How do these suggestions relate to current practice in your country/experience? Are they implementable in your country/experience?

Curriculum should be strongly incorporating examples and situations inspired by the community CHWs are serving in terms of language, cultural & religious beliefs/practices, as should training activities be.

Training delivered in CHWs usual work premises helps empowering them in their role and brings an added value & understanding to the whole training process as admin / care providers / members of community might see it happening

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Q4. Recommendation 5 suggests using competency-based formal certification for CHWs who have successfully completed pre-service training. How does this suggestion relate to current practice in your country/experience? Is it implementable in your country/experience?

Certifying training is must.

In our experience, the certification we delivered after written & oral examination process was in itself a training & empowering process! For many CHWs they had never sit exam before, they went through tough stress management process with fear to fail it and were very proudly holding their certificates during ceremony as it was in majority of cases their first degree ever received. Some brought their husbands or children and were referred as role models.

Another suggestion is to have a ceremony or celebration as must as well, to celebrate completion of training, acknowledging CHWs efforts and empowering them in their community they are serving / belonging to.

A celebration of success was organized with delivering of certificates, and another ceremony was held inviting the whole community to discover the new offer CHWs were providing.

Always good to gather top administrators, doctors, nurses, community members, families with CHWs to help putting some light on their work.

I will try to share comments in the french HIFA group as well, as french is my first language. I would love to be participating in this group.

I am currently living in Cairo, but home base is in Geneva/Switzerland, and be returning there for the summer.

I would be available from June 30th to attend meetings should it be needed for this working group.

I have submitted request to join HIFA (french & English) and am waiting for reply, looking forward to working with the team.

warm regards,

Anbreen



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HIFA profile: Anbreen Slama-Chaudhry is a medical doctor, NCDs Management Consultant & Patients Health Advisor, Patients-Communities Health Empowerment & Capacity Building, Switzerland / Egypt. <https://medicaltrainingservices.ch/home/> anbreen.slama.chaudhry AT medicaltrainingservices.ch

## CHWs (141) CHWs and mental health (4) MEDBOX Mental Health Toolbox

11 July, 2019

Mental Health Knowledge for Action and Prevention

It has been very often read and heard in the last years - the still very impressive statement - that about 450 million people suffer from mental disorders according to estimates given in one of the WHO's World Health Report. The question arising is:

How many more lives will add to this number and what can the Mental Health community do in order to prevent an increase while working together in better solutions for those already living with mental illness? And how can society be empowered to not only protect themselves by working on their own mental well-being, but also extending their listening and empathy to those going through mental illness?

How can stigma be eradicated giving room to understanding and acceptance to those in need of Mental care?

Surprisingly, in a world of on-going exchange of information and resources, still many countries are lacking of an efficient access to Mental Health related knowledge, literature, best practice and guideline resources, and furthermore, the prevention strategies aren't accessible or not even known or included in many policy programs.

On behalf of MEDBOX, today we want to bring up a basic principle that it also applies to the work of achieving Mental Health for all: Knowledge is

power and it is through knowledge that both, prevention and action, can flourish in a platform of informed and united communities. What our medical encyclopedia has to offer to the Mental Health community is precisely this; the knowledge needed to empower individuals to prevent, to act and to train others.

Since April 2019 MEDBOX [www.medbox.org](http://www.medbox.org) has available a new MENTAL HEALTH TOOLBOX [www.mentalhealthbox.org](http://www.mentalhealthbox.org) with a huge amount of resources available for mental health professionals, health worker and anyone ready to take heart and join in the arduous but not impossible goal of achieving a better Mental Health Care.

As Didier Demassosso (HIFA country representative for Cameroon) stated in a recent HIFA forum: “Without knowledge on what mental illnesses are what mental health is and how mental health services should be developed to address the continuously growing needs of populations now more interconnected than ever before, would we be ensuring our future with the people needed to manage it?”

Kind regards,

Nazareth Bonilla Pérez  
MEDBOX Project Assistant

Sieglinde Mauder  
MEDBOX Project Manager

[www.medbox.org](http://www.medbox.org)  
[www.mentalhealthbox.org](http://www.mentalhealthbox.org)

HIFA profile: Sieglinde Mauder is Librarian at the Medical Mission Institute, Würzburg, Germany. She collects and distributes resources on HIV/AIDS, tropical diseases, humanitarian aid, health service management, e-learning for partners in developing countries. sieglinde.mauder AT medmissio.de

## CHWs (142) BMJ Global Health: Is quality affordable for community health systems?

11 July, 2019

[Sharing this paper as it may inform the ongoing thematic discussion about CHWs/WHO guideline, thanks MMC]

CITATION: Kumar M B, Madan J J, Aching M M, Limato R, Nima S, Kea A Z, Rex Chikaphupha K, Barasa E, Taegtmeier M Is quality affordable for community health systems? Costs of integrating quality improvement into close-to-community health programmes in five low-income and middle-income countries *BMJ Global Health*. 2019

<https://gh.bmj.com/content/4/4/e001390>

## ABSTRACT

### Introduction

Countries aspiring to universal health coverage view close-to-community (CTC) providers as a low-cost means of increasing coverage. However, due to lack of coordination and unreliable funding, the quality of large-scale CTC healthcare provision is highly variable and routine data about service quality are not trustworthy. Quality improvement (QI) approaches are a means of addressing these issues, yet neither the costs nor the budget impact of integrating QI approaches into CTC programme costs have been assessed.

### Methods

This paper examines the costs and budget impact of integrating QI into existing CTC health programmes in five countries (Ethiopia, Indonesia, Kenya, Malawi, Mozambique) between 2015 and 2017. The intervention involved: (1) QI team formation; (2) Phased training interspersed with supportive supervision; which resulted in (3) QI teams independently collecting and analysing data to conduct QI interventions. Project costs were collected using an ingredients approach from a health systems perspective. Based on project costs, costs of local adoption of the intervention were modelled under three implementation scenarios.

### Results

Annualised economic unit costs ranged from \$62 in Mozambique to \$254 in Ethiopia per CTC provider supervised, driven by the context, type of community health model and the intensity of the intervention. The budget impact of Ministry-led QI for community health is estimated at 0.53% or less of the general government expenditure on health in all countries (and below 0.03% in three of the five countries).

### Conclusion

CTC provision is a key component of healthcare delivery in many settings, so QI has huge potential impact. The impact is difficult to establish

conclusively, but as a first step we have provided evidence to assess affordability of QI for community health. Further research is needed to assess whether QI can achieve the level of benefits that would justify the required investment.

Countries represented in the review: Ethiopia, Indonesia, Kenya, Malawi, Mozambique

HIFA profile: Martin Carroll was previously Head of the International Department at the British Medical Association, London UK, and has worked on issues affecting health in LMICs since 2003. He represented the BMA on the HIFA Steering Group from 2008-16 and is now an independent adviser to the group. martin\_c63 AT hotmail.com

## CHWs (143) Thank you

13 July, 2019

Dear HIFA colleagues,

We are now coming to the end of our first thematic discussion on the CHW Guideline. <http://www.hifa.org/news/who-hsg-hifa-collaboration-empowering-community...>

We have expressed our thoughts on the Guideline, in particular Recommendations 1 (selection), 2 (length of pre-service training), 3 (competency domains), 4 (modalities), and 5 (certification). And we have had thought-provoking contributions on many other aspects of CHWs.

We have heard the experience of CHW programmes in several countries, including some of the direct experience of CHWs themselves (we would love to hear more).

In the coming days we shall provide you with a compilation of the whole discussion; 'long edit' and 'short edit' versions; and metrics on contributors.

To paraphrase Churchill, this is just 'the end of the beginning' of our work together to promote, explore and implement the CHW Guideline. The World Health Organization has generously sponsored HIFA to continue our work for the coming year (and beyond). Part of our work plan is to implement three thematic discussions, the first of which is now concluding. We are now planning a second thematic discussion to take place later this year. The other part of our work is to encourage and promote sharing of experience, publications, resources on any aspect of CHWs throughout the whole period

of the project. To help us I would like to invite expressions of interest for a volunteer to join the HIFA working group on CHWs as a 'HIFA catalyst'. His/her role would be to keep an eye on the CHW literature and 'community' and notify HIFA of any new developments or publications relevant to CHWs. If you are interested, please contact me: [neil@hifa.org](mailto:neil@hifa.org)

(Note: Sponsorship of HIFA projects/thematic discussions from organisations such as WHO, The Lancet and Elsevier is critical for HIFA's financial viability. If you and your organisation would like to learn more about sponsorship opportunities, please get in touch.)

On behalf of the HIFA project on CHWs I thank everyone who has contributed to this first thematic discussion. I hope you have benefited and learned as much as I have.

Best wishes, Neil

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: [www.hifa.org](http://www.hifa.org)

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org) ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

CHWs (144) WHO releases first guideline on digital health interventions (14) Recommendation 7: WHO recommends the use of digital decision support

13 July, 2019

Dear HIFA colleagues,

I would like to invite discussion on Recommendation 7 of the WHO Guideline on Digital Health, launched in April this year.

The full guideline is available here: <https://apps.who.int/iris/bitstream/handle/10665/311941/9789241550505-en...>

Recommendation 7: WHO recommends the use of digital decision support accessible via mobile devices for community and facility-based health

workers in the context of tasks that are already defined

within the scope of practice for the health worker.

(Recommended only in specific contexts or conditions)

This guideline question specifically explores 'the added value of digital decision support tools available at primary health care levels and accessible to health workers via mobile devices'.

It notes: 'There is limited evidence on the effectiveness of health worker decision support via mobile devices directed to clinical health workers. For the intervention directed to community health

workers, the evidence suggests that this may have positive effects on individuals taking prescribed medication but may make little or no difference to the individuals' overall health status. When

directed to community health workers, decision support may make little or no difference to clients' satisfaction with the information they receive.'

'The qualitative evidence suggests health workers find the intervention useful and reassuring for guiding the delivery of care. However, some health workers perceive algorithms as too prescriptive,

and are concerned that they may lose their clinical competencies by blindly following treatment algorithms. The evidence also suggests that clients find the intervention acceptable and enables health workers to be more thorough when providing care.'

COMMENTS/QUESTIONS (NPW):

1. "WHO recommends the use of digital decision support accessible via mobile devices for community and facility-based health workers". Yes. Can we say more about the typology of decision support tools? What do we know about the impact of specific tools in specific contexts?

2. "in the context of tasks that are already defined within the scope of practice for the health worker". I find this over-restrictive. For me it makes more sense to say something like "with content and format that are reliable and relevant to the practice of the health worker". Such content should include information to recognise health situations that require urgent referral. It is dangerous actively to restrict health workers' knowledge.

3. "For the intervention directed to community health workers..." The focus

on CHWs is interesting. It would be valuable to analyse the roles of digital decision support across different cadres in different clinical contexts.

4. "this may have positive effects on individuals taking prescribed medication" I don't see how decision support for CHWs can promote patients to take medicines.

5. "When directed to community health workers, decision support may make little or no difference to clients' satisfaction with the information they receive." Would one expect decision support for CHWs to lead to client satisfaction with the information they receive?

6. "Some health workers perceive algorithms as too prescriptive" There is a difference between finding a specific algorithm too restrictive and a blanket rejection of algorithms. If the former, consideration needs to be given to the content and presentation of the algorithm. If the latter, then the health worker needs better education and training. Also, what is important is whether the algorithm helps the health worker make better decisions. If it doesn't do that, then it needs to be revised accordingly.

I offer the above not as criticism of the Recommendation, but to explore the issues raised.

Best wishes, Neil

Coordinator, mHIFA Project (Mobile Healthcare Information For All)

<http://www.hifa.org/projects/mobile-hifa-mhifa>

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