



## **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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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

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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 unnecessary 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 Bryan 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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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 (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 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.

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 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>

Join HIFA-French: <http://www.hifa.org/join/rejoignez-hifa-francais>

Join HIFA-Spanish: <http://www.hifa.org/join/unase-hifa-espanol>

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...> 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, 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 (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.

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## **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>

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[\*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 issues including confidentiality? I agree with some thought to get blessings the community this should include opinion leaders? Faith-based leaders should be involved...

My other thought is that to what extent the would quacks would be prevented from masquarading? 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 providening 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 133139, 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 Binagwaho [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.

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## **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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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 (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.

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

write2sunanda AT gmail.com

## 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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## **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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## **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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# 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:

--

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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## **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.

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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

Source link:

<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

Rebecca Furth

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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 Tulsi 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 - Tulsi Chandrai PHC model was to work with a community who nominate their indigene (s) and are screened by Tulsi 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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# **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).

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>

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