CHWs (62) Ebola in DR Congo (3)

14 June, 2019
Thanks Joseph for the updates and highlights on ebola

Actually the Ebola situation in Congo and the boarders of Uganda as observed is an example of why we need to embrace the CHW who can educate communities on some of these deadly diseases. Cause am told the people still think that Ebola is witchcraft as it was with HIV in Uganda when it had just been detected. CHWs can dymsfy myths better if well trained. More so, knowing that we dont have enough medical people to do facility work and community work.

Thats what I think

Happy

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

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

14 June, 2019
Dear All,

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

As Chief Executive of a state ministry of Health in Nigeria that upgraded a school of Health Technology to a College of Health Technology in our overall plan to strengthen the health system with the anchor as the primary health care tier including expanding the system to a multi sectoral and multi disciplinary PHC, I was involved in preparing designing, drafting and implementing the plan. We head-hunted the leadership of the college looking for persons health professionals with PHC experience and expanding the curriculum of the college once it received legal Act from the State House of Assembly. Then we looked around the country for models that we could adopt for the state: I spent one working week with a non governmental NGO called Tulsi Chandrai Foundation (TCF) in another state (Kaduna state) in the Northern part of the country and conducted daily study tours with the NGO staff as they visited CHWs in their stations including doing Home visits. I was impressed so that on returning to my base in Calabar, I sent a team of CHW and nurses/midwives to do what I had just done in Kaduna state.

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

I should add that while some of the pre-training selection criteria and attributes listed in the WHO guideline are easier to implement even in the TCF model (even though we did not ourselves specifically use them in that way in Calabar) including 'a demonstrated commitment and attitude to community service', 'being proactive, cooperative and adaptable', some other criteria may be more difficult to implement in many LMICs such as

'leadership skills', 'prior relevant work experience', and 'relevant cognitive skills'. And even other criteria may be almost impossible to implement at the pre service selection stage, and I rather think that they should await the post training / recruitment stage such as 'the capacity and willingness to progressively develop an understanding of the local context and community'. The shortage of human resource in health who would comprise the selection team is the main reason why the selection criteria need to be a bit less stringent and contextual, if the recruitment is to remain attractive for applicants and workable for the selectors.

Joseph Ana

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

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

14 June, 2019
Happy, thank you for your suggestion on the need to engage more CHW to fill the gaps n the field that have arisen due to the shortage of human resources in health (HRH) not only in DR Congo but across the globe.

The problem is more acute in LMICs especially Africa where as you rightly say, 'the people still think that Ebola is witchcraft as it was with HIV in Uganda when it had just been detected'. It is astonishing to see how long this witchcraft myths has persisted in LMICs particularly in Africa, inspite of

the all-time high registration in education in the continent. It seems that the more people are educated the more health myths persist. Surely, it illustrates how weak the health systems are, that they fail to eliminate such myths. How health education is not given the right priority in country after country. Sadly, it has a direct correlation with the failure to bridge the gap in the health worker: population ratio, as long as the shortage of HRH persists.

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

Joseph Ana

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

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

14 June, 2019
WHO has this week published a new Fact Sheet on Rehabilitation. Read online here: https://www.who.int/news-room/fact-sheets/detail/rehabilitation

13 June 2019

KEY FACTS

- Rehabilitation is a set of interventions needed when a person is experiencing or is likely to experience limitations in everyday functioning due to ageing or a health condition, including chronic diseases or disorders, injuries or traumas. Examples of limitations in functioning are difficulties in thinking, seeing, hearing, communicating, moving around, having relationships or keeping a job.

- Rehabilitation is an essential component of universal health coverage along with promotion, prevention, treatment and palliation.

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

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

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

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

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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

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

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - 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

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

15 June, 2019
Dear all,

I am an epidemiologist working on disease control in emergencies.

I am looking for any descriptive reports, training materials, and evaluation reports on CHW programmes focusing on community-based NCD control. I am particularly interested in humanitarian settings and fragile states, but also programmes in LMICs. Some examples (Mexico:

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

Lebanon for Syrian refugees:

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

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

Information on our study:

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

We are looking for more insights and evidence from CHW programmes that address diabetes and hypertension in the community. We are trying to

incorporate lessons learned from other programs -- as there are so few, and next to none that are published.

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

Ruwan

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

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

16 June, 2019
Dear HIFA colleagues,

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

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

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

RECOMMENDATION 2:

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

• scope of work, and anticipated responsibilities and role;

• competencies required to ensure high-quality service delivery;

• pre-existing knowledge and skills (whether acquired through prior training

or relevant experience);

• social, economic and geographical circumstances of trainees;

• institutional capacity to provide the training;

• expected conditions of practice.

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

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

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

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

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

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

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

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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

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

16 June, 2019
Dear Colleagues: 15 June, 2019

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

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

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

Respectfully,

Nicholas Cunningham MD Dr P.H.

HIFA profile: Nicholas Cunningham is Emeritus Professor of Clinical Pediatrics & Clinical Public Health at Columbia University, New York, USA. He is interested in International Primary Maternal and Child Health Care, community owned, professionally overseen, and supported by $/power interests, encorporating integrated cure/prevention, midwifery/child care, child saving/child spacing, nutrition/infection, health/education (especially female), monitored but not evaluated for at least 5-10 years, based on

methods pioneered by David Morley at Imesi (Nigeria) and by the Aroles at the Jamkhed villages in Maharashtra State in India. Totatot AT aol.com

CHWs (69) What do community health workers want?

16 June, 2019
Below are the citation and abstract of a new paper in BMJ GlobalHealth,and a comment from me.

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

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

ABSTRACT

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

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

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

higher level of education and less likely to be the main income earners for their families.

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

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

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

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

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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

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

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

16 June, 2019
Prof Cunningham thank you for your posting.

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

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

Joseph Ana

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

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

17 June, 2019
I reproduce in full Recommendation 2; Implementation considerations for this Recommendation; examples from Ethiopia, Mozambique and Pakistan; and a Comment from me below.

RECOMMENDATION 2

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

• scope of work, and anticipated responsibilities and role;

• competencies required to ensure high-quality service delivery;

• pre-existing knowledge and skills (whether acquired through prior training or relevant experience);

• social, economic and geographical circumstances of trainees;

• institutional capacity to provide the training;

• expected conditions of practice.

IMPLEMENTATION CONSIDERATIONS

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

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

As these vary substantially based on the role that CHWs play, it is expected that CHWs with a polyvalent role and working on a full-time or regular basis (that is, those delivering more complex interventions or a wide range of primary health care services) would require longer training than those providing a single focused service on a more occasional basis. Table 3 [see below] provides selected examples of pre-service education that is

considered by national policy-makers to be of appropriate duration (typically several months) in relation to the learning objectives of CHWs with a polyvalent role. CHWs with a more limited set of responsibilities have a shorter pre-service education (for example, 23 days for accredited social health activists in India) (67).

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

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

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

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

12 months (30% theoretical, 70% practical)

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

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

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

15 months (20% theoretical, 80% practical)

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

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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

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CHWs (72) Reflections on CHW Discussion Week 2

17 June, 2019
Greetings!

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

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

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

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

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

Thank you,

Amelia

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

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

17 June, 2019
Tijani, thank you for sharing your experience of being a community health worker [http://www.hifa.org/dgroups-rss/chws-54-selection-chws-pre-service-train…. It is so instructive, and I sincerely hope we hear from other CHWs as well.

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

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

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

Again, thank you for your valuable contribution.

Amelia

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

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

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

17 June, 2019
Dear community,

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

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

Regards,

Héctor Carrasco

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

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

17 June, 2019
In Nigeria the CHW / CHP are trained to play 'polyvalent' role in the primary health care tier of the health system.

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

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

The most recent information on numbers and density of health workers is available in the “Nigeria Health Workers Profile published in 2013. There are huge discrepancies between total numbers in the Registries kept by the

regulatory councils and those deemed to be "in good standing", the latter is far more likely, reflecting a the weakness of the councils and the numbers of thevarious cadres in active practise in Nigeria, with a population of about 193 million..

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

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

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

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

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

Therefore, the duration and curriculum for training CHWs focuses on key priority areas such as Family and Reproductive Health, Maternal and Child Health services (RMNCH), as well as HIV, TB, Malaria, other Communicable diseases and neglected tropical diseases, and Non-Communicable Diseases. Some of the details include:

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

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

Joseph Ana

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National Implementing Organisation: PACKNigeria Programme for PHC

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

17 June, 2019
Hi Ruwan,

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

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

Best regards,

Becky
Technical Manager CHWCentral

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

CHWs (77) Resources and CoPs for CHW programming

17 June, 2019
Dear HIFA Community,

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

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

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

Finally, the WHO task sharing guidelines to optimize health worker roles for maternal and newborn health provide a comprehensive look at WHO recommendations for addressing global health worker shortages [https://www.who.int/reproductivehealth/publications/maternal_perinatal_h…. The Guideline is offered in an interactive format [https://optimizemnh.org/] that outlines the ranges of services WHO

recommends for various health workers. A summary specific for family planning has also been developed and can be found on the WHO website here [https://apps.who.int/iris/bitstream/handle/10665/259633/WHO-RHR-17.20-en...].

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

Nandita Thatte, IBP Initiative

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

www.hifa.org/projects/family-planning www.hifa.org/support/members/nandita

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

18 June, 2019
Dear HIFA colleagues,

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

RECOMMENDATION 3

WHO suggests including the following competency domains for the curriculum for pre-service training of CHWs, if their expected role includes such functions.

Core:

• promotive and preventive services, identification of family health and social needs and risk;

• integration within the wider health care system in relation to the range of tasks to be performed in accordance with CHW role, including referral, collaborative relation with other health workers in primary care teams, patient

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

• social and environmental determinants of health;

• providing psychosocial support;

• interpersonal skills related to confidentiality, communication, community engagement and mobilization;

• personal safety.

Additional:

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

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

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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

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

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

18 June, 2019
Dear HIFA,

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

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

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

best wishes,

Alison Nicholls RN

UK Advanced Nurse Practitioner

HIFA profile: Alison Nicholls works at Trinity College, Oxford, UK. alison.nicholls AT trinity.ox.ac.uk

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

18 June, 2019
Dear HIFA colleagues,

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

1. Is there an official scope of work for CHWs in your context? If so, does pre-service training align to this scope of work?

2. What CHW competencies are required to ensure high-quality service delivery in your setting?

3. Is there pre-service training for CHWs in your context? If so, how is the pre-service training presented? Does the pre-service training align with the required competencies?

4. Is the pre-service training curriculated? If so, how has the curriculum been compiled? Is the curriculum credit-bearing and/or aligned to a qualifications framework?

5. What institutions have the capacity to provide training? Are trainees able to access the institution/s providing training (especially in terms of social, economic, and geographical realities)?

6. Is prior learning recognised in pre-service training in your context? If so, how is the recognition of prior learning (RPL) facilitated?

7. What are the conditions of practice for CHWs in your setting? Is the CHW pre-service training aligned to these conditions?

Access the CHW Guideline here:

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

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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

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

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

18 June, 2019
Dear All,

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

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

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

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

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

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

The need for a new cadre of worker in the rehabilitation field was advocated by WHO in 1981 because of shortage of highly trained professionals to address the problem of disabilities in rural areas (besides the fact that professionals are used to working in technology oriented settings). In our own programme we felt there was a significant value in training Community workers to provide basic home based services (mainly therapy) on a daily basis. However, the level of education in the community was not high (a school leaving certificate in most cases). Hence, our preselection criteria included a grid which looked at 3 categories, viz. ESSENTIAL (basic cognitive skills, language proficiency, high school education, an understanding of local community, and an interest/ willingness to learn), DESIRABLE (pleasant/cheerful personality, good communication skills, graduation, being a resident of the area or a place close by) and OPTIONAL (previous work experience, helping a friend or a family member with disability).

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

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

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

The less educated of the workers are often the best for practical work with mothers and children but the graduates are better at documentation of work. We continue with the practice of pairing the less educated older

women (with better managerial skills) for work with the young graduates as they complement each other with their knowledge and skills.

I know that not all of the criteria apply to all CHWs and no single system is appropriate to all programmes. Area of coverage, interventions, concomitant Community Development work, and the target beneficiaries often decide the criteria for selection.

Thanks and regards,

Sunanda

Dr. Sunanda K. Reddy
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HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi,India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads (www.carenidhi.org). 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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CHWs (82) Certification of CHWs

18 June, 2019
I noticed this article today on transfer of certification between provinces in Canada. Does anyone else have insights on CHW certification at the national

or sub-national level (globally) and plans in place to enable workers to move within their country?

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

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

CHWs (83) Kenya experience in CHW training

19 June, 2019
Kenya Experience in CHW Training

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

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

Competencies of CHEWs

1. Plan and mobilise resources to support health plans at community level

2. Manage/supervise/lead CHVs at community level

3. Communicate/coordinate stakeholders at community level

4. Supervise data collection, entry and dissemination

5. Monitor and evaluate programs at community level

Training

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

CHVs

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

Training of CHVs takes six weeks.

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

CHWs (84) Certification of CHWs (2)

19 June, 2019
[In response to Catherine Kane's question: Does anyone else have insights on CHW certification at the national or sub-national level (globally) and plans in place to enable workers to move within their country?]

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

Joseph Ana.

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

CHWs (85) Certification of CHWs (3)

19 June, 2019
Recommendation 5 of the CHW Guideline says:

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

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

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

'A key component of quality health care delivery is workforce standards. This implies defining professional roles, scope of work, responsibilities and tasks, along with educational standards and minimum competency requirements for different health service positions. Credentialing provides a formal recognition awarded to those meeting predetermined standards (93). The

availability of and requirements for CHW certification vary across countries. In many cases, CHWs have been identified as “community volunteers” and are casually trained to provide services in the community without any clear mechanism for certification. In some countries, however, standards and procedures for CHW certification exist.

'For CHWs, certification programmes might have some theoretical benefits: certification may increase their motivation, sense of self-esteem and respect from other health workers. Certification that describes the learning achieved enables transferability to other settings, thus reducing the need to repeat training if the worker moves location; or it can be used as evidence as part of admission criteria for further education. In some countries, certification can legitimize the work of CHWs and provide opportunities for the reimbursement of CHW services (94). From the perspective of citizens and communities, formal certification may protect the public from harm resulting from the provision of inappropriate care rendered by providers lacking any training but purporting to be qualified (95).

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

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

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

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

Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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

Access the CHW Guideline here:

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

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

CHWs (86) Certification of CHWs (4)

19 June, 2019
Hi Catherine,

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

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

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

Best,

Becky

Technical Manager CHW Central

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

CHWs (87) Compilation of messages during week 2

20 June, 2019
Dear HIFA colleagues,

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

http://www.hifa.org/sites/default/files/articles/CHW_discussion1_compila...

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

The compilation of messages during week 1 is available here:

http://www.hifa.org/sites/default/files/articles/CHW_discussion1_compila...

To contribute to the discussion, please send email to: hifa@hifaforums.org

With 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), 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

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

20 June, 2019
In South Africa there has been an attempt at regulating allied health professionals through The Allied Health Professions Council of South Africa (AHPCSA).

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

https://ahpcsa.co.za/

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

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

Kind regards

Maryam Rumaney

Maryam Bibi Rumaney
Scientific & English language editing consultant

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

www.mbrumaney.co

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

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

20 June, 2019
Thank you, Stephen, for providing that detailed information about Kenya's CHW training protocols.

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

coordinate with the national program regarding CHW selection and training? Hearing from these organizations would greatly enrich the conversation.

Thank you,

Amelia

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

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

asiplant AT gmail.com

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

20 June, 2019
Dear HIFA colleagues,

(btw Amelia, thanks for your message just now about NGOs - I do hope we can learn from their experience)

I am fascinated by Recommendation 3, which in my personal (non-expert) view is one of the most important of the 15 Recommendations. I reproduce below the Recommendation, the rationale for it, how the evidence should be interpreted (as described by the Guideline), and a personal comment from me.

RECOMMENDATION 3

WHO suggests including the following competency domains for the curriculum for pre-service training of CHWs, if their expected role includes such functions.

Core:

• promotive and preventive services, identification of family health and social needs and risk;

• integration within the wider health care system in relation to the range of tasks to be performed in accordance with CHW role, including referral, collaborative relation with other health workers in primary care teams, patient tracing, community disease surveillance, monitoring, and data collection, analysis and use;

• social and environmental determinants of health;

• providing psychosocial support;

• interpersonal skills related to confidentiality, communication, community engagement and mobilization;

• personal safety.

Additional:

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

WHAT IS THE RATIONALE FOR RECOMMENDATION?

'The GDG recognized that the heterogeneity of roles played by CHWs requires and benefits from considerable flexibility in determining the contents of curricula for pre-service education. The logic underpinning the recommendation was that while roles – and thus competencies required – may vary, the general principle, supported by some limited evidence, is that the addition of specific competencies

and skills to the curriculum improves the capacity and performance of CHWs to perform the corresponding task(s). The recommendation was framed as a conditional one, recognizing both the importance of adapting it to national and local context and the moderate certainty and very limited scope of the underpinning evidence.'

HOW SHOULD WE INTERPRET THE EVIDENCE?

'The scope and roles of CHWs vary substantially across countries and CHWs, hence it is not possible to standardize the scope of pre-service education and contents of curricula. This is already reflected by the wide variations in

the content of training curricula across countries, with some countries emphasizing predominantly competencies relating to reproductive, maternal, newborn and child health and others taking a broader approach. Some curricula, for example, focused exclusively on preventive and promotive interventions, while others also included diagnostic and curative competencies. The evidence identified through the systematic review, while of moderate certainty, refers to a single type of CHW in a single country, hence it is of limited generalizability and applicability. The inclusion of competencies in curricula should therefore be guided by requirements in the national context, while also reflecting international best practices, as also reflected in other WHO guidelines.'

COMMENT (NPW): This Recommendation, like most of the other recommendations, is conditional, emphasising the heterogeneity of most aspects of CHWs and CHW programmes, and the limitations of standardisation. The Recommendation goes further by stating 'it is not possible to standardize the scope of pre-service education and contents of curricula'. This is in stark contrast to some of the HIFA discussions we have had in previous years, where many (not all) HIFA members have advocated for standardisation of the CHW curriculum.

So how do we interpret this Recommendation and where should we go from here? Should each country sort out its own curriculum for CHWs (which, as we have seen in Nigeria, may be multilevelled)? Are there advantages to make training modular, so that all CHWs in a given country would have the same pre-service training, with the option to specialise later by taking further modules? Is there a case for standardising any of the curriculum, whether globally or regionally? What does all this mean for sharing of experience and expertise among different countries?

Best wishes, Neil

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

Access the CHW Guideline here:

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

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