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

Week 6 Compilation

CHWs (126) Certification of CHWs (11) New message from Daniel Stern, Tanzania/Uganda

5 July, 2019

[Note from HIFA moderator (NPW): I am forwarding this on behalf of Daniel Stern, Tanzania/Uganda]

Dear Becky, thank you; seems you have hit the nail on the head; how do we maintain the dynamism and diversity of CHWs as programs formalize?

I believe there is a trade-off, i.e. the illiterate CHW whose extraordinary healthcare skills to a great extent depend upon her ability, as an illiterate person, affords him or her to enter other worlds, seamlessly, and would be in danger of losing this magnificent facility, were required literacy foisted upon them in an unnatural way. I had the pleasure of hosting a leader of the Ik people at my home in Kampala. The Ik are hunter gatherers in the extreme north east of Uganda. His people are illiterate, yet he had university degrees that enabled him to deal with government officials such that his people would not be unnecessarily abused, even by well meaning government. And yet he could still move comfortably between the two or more worlds he lived in. I believe we must be more sensitive in respecting the spiritual side of healing. If you will read Harvard's Dr. Atul Gawande' book, Complications about his surgical residency he touches on this subject delicately, in the last chapter, The Red Leg. The Ugandan traditional midwives I spent time with would deliver breach births effortlessly, without an ultrasound, for they SEE, by virtue of their spiritual gifts.

Dr. Joseph Ana recently mentioned in this same forum how "inter professional disharmony (which seems to be an oxymoron) was a huge problem that undermined the strengthening of quality care, which I would suggest was part of the downside of literacy.

Thanks again, and best wishes, Daniel

HIFA profile: Daniel Stern is a HIFA Representative and member of the mHIFA WG. He is a member of Uganda MCH TWG. Daniel is Co-founder of the educational NGO Uconnect, and of the Innovation Hub, Hive Colab, and is also Cofounder of ISOC Uganda and Uganda IXP. He is a UN WSA National Expert. His Uconnect team distributes off-line E-Learning content, including Hesperian Health Guides to schools in East Africa since 2008. During his six-years as Lead for Uganda Mobile Monday he regularly organized events with mobile health themes, usually in collaboration with UNICEF's Uganda team, and their pan African IntraHealth efforts to improve interoperative healthcare systems, both within and between countries,in mHero, such that developer- entrepreneurs's apps would align with the latest trends by MoH policies. http://www.hifa.org/support/members/daniel

DStern AT Uconnect.org

CHWs (127) Certification of CHWs (12)

5 July, 2019

Dear Becky,

You are spot on, and the situation is not any different in Uganda where CHWs with low levels of education make a contribution in improving health in their communities. Whereas certification of CHWs requiring high levels of education is welcome, we need not forget those who may not meet the requirements yet have a wealth of knowledge and experience in offering primary health care and public health services in their communities.

Best wishes,

David

HIFA profile: David Musoke is a Lecturer at the Makerere University School of Public Health, Uganda. Professional interests: Malaria prevention, community health workers, environmental health, public health, disadvantaged populations. He is a member of the HIFA working group on CHWs. www.hifa.org/projects/community-health-workerswww.hifa.org/support/members/david-0 dmusoke AT musph.ac.ug

CHWs (128) Certification of CHWs (13) New message from Daniel Stern, Tanzania/Uganda (2)

5 July, 2019

Daniel Stern has delightfully covered some interesting themes in his posting: 'Illiterate CHW and their entrance into a different world'; 'Traditional Birth Attendants (TBAs) practicing advanced skills like breech delivery without US Scans'; 'spiritual side of healing'; 'inter professional disharmony and its negative effect on health system strengthening'.

All of which could actually form the basis for deeper discussions and analysis.

For instance more light could have been thrown on how illiterate CHW get to learn the basic knowledge that underpinned the health information that they pass on to the community in their health promotion and prevention roles and if they have to engage in even the most basic treatment roles how do they learn the necessary skills. How would illiterate persons who want to be CHW enter the world that WHO guideline describes: selection, training, certification, practice, etc.

It is very interesting to read that TBAs deliver complex presentations like breech during childbirth without equipment aids. Before US Scan was discovered in health practice, skilled personnel conducted such deliveries, following training and apprenticeship. How do the TBAs learn to do it? And what is their success rate or failure rate?

A very close relative of mine recently pursued the theme of spirituality and healing to a University Masters degree and came up tops with MA (distinction), so it is increasingly an important topic to be on the front burner, especially given the challenges that arise in health and medical practice in a world that is struggling with spiritualism, religion and a spectrum of atheism and Big Bang theory.

It would be nice to hear members comment on inter professional disharmony, which as I said forms a huge spanner that is hindering efforts to strengthen the health system in Nigeria. Does it exist in other countries, what are the causes and effects, and what is being done to stamp it out / control it?

Joseph Ana

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

http://www.hifa.org/support/members/joseph-0
http://www.hifa.org/people/steering-group
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CHWs (129) Compilation of messages during week 4

5 July, 2019

Dear HIFA colleagues,

Thank you once again for all your valuable contributions to this discussion so far!

Please find here a compilation of messages during week 4 (21-28 June 2019), with thanks to HIFA volunteer Sam Pakenham-Walsh:

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

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

Background to the discussion, questions and all compilations are available here:

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

(scroll down to see the PDF links)

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

We welcome any message that relates to CHWs, at any time. We are carefully documenting and collating all the key points and these will help inform future action.

With thanks, Neil

Coordinator, HIFA Project on Community Health Workers

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

Access the CHW Guideline here:

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

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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 (130) What can Herbal or Traditional medicine treat?

5 July, 2019

From now I will be addressing issues concerning Traditional medicine practice.

I think it will be too elementary going back to defining traditional medicine this time around, over the years WHO has provided us with distinctive definition and definition for its practitioners. So for this report I want to address the above questions.

Herbal medicine can treat almost any condition that patients might take to their doctor. Qualify herbalists know when a condition is best seen by a doctor or another therapist.

Nobody is an island of knowledge, herbalists and other traditional medical practitioners do not relegate, discriminate other knowledge, idea or skill no matter how little or crude it may seem. Herbalist believes, and holds knowledge possess by other people in high esteem. The Yoruba language for medicine is a prove to this 'Oogun' - something extended, without end, or infinity. They even went ahead to propound that "where someone else knowledge about it stops, there begins another person" ibi ti teni kan pari si ibe ni ti elomiran ti bere. Eni to mo eyi ko mo eyi.

I recollect my father of blessed memory told me he had to treck 9 or more miles away to meet people whom he heard possess a type of document, skill or knowlege for a particular medication of a disease. He would go to them, exchange pleasantries, and been a staunch practitioner, they would exchange ideas.

Nature has provided us with all the solutions to our problems, we only need to look in more deeply to discover surrounding values, those values that are very essential for human health.

"Medical herbalists are trained in the same diagnostic skills as orthodox doctors but take a more holistic approach to illness. The underlying cause of the problem is sought and once identified, it is this which is treated, rather than the symptoms alone. The reason for this is that treatment or suppression of symptoms will not rid the body of the disease itself. Herbalist use their remedies to restore the balance of the body thus enabling it to mobilize its own healing power.

Many of the pharmaceutical drugs used today are based on plants constituents and, even now, when scientists are seeking new 'cures' for disease it is to the plant world that they turn. They find, extract and then synthesise in the laboratory a single active constituent from the plant (the active constituent is the part of the plant that has a therapeutic value), this can then be manufactured on a large scale.

However, people have always relied on plants for food to nourish and sustain the body. Herbal medicine can be seen in the same way. Plants with a particular affinity for certain organs or systems of the body are used to feed and restore to health those parts which have become weakened. As the body is strengthened so is its power and ability to fight off disease and when balance and harmony are restored, health will be regained.

Herbalists believe that the active constituents are balanced within the plant and are made more or less powerful by the numerous other substances present. It will be difficult to analyse completely the whole chemical constituent especially when dealing with natural healing, still lies hidden secret that only nature understands how it works. Herbal drugs, however are extracts from a part of the whole plant e.g leaves, roots, etc and contains hundreds, perhaps thousands of plant constituents". Journal of Christian CAM practitioners. UK

What really works in herbs are in the originality of it being natural. Psalm 104 vs 14 - And HERBS for the services of man. Nature has granted all our body required for its services and for better functioning, for the correction of every malfunctioning and management of it. The secret of the elements that works is limited to the scientific analysis. The mysteryr is in the WORD spoken by the nature that created them. The WORD will never end, it is eternity, and that is God. Science may believe in what they see and can analyse but still what is essential is invisible to the eye. Thunder don't just strike, a force controls it, forces scientific can not see.

Like attracts likes, iron sharpens iron, so is human and other natural gift, they can only complement each other. The word of Hippocratic still relevant - let your food be your medicine and your medicine your food. Vegetables, fruits, fish, eggs, palm oil, okra, water are the medicine for hunger, once you refuse to take them your body becomes restless, headache set in, loss of sleep, isolation with social well-being, because you nag often, but once, they are taking body becomes active then they are medicine. Once food is not taking in the correct proportion diseases set in, not blood tonic or chemotherapy is capable of restoring health, but adequate diet which are composed of HERBS, what are these herbs? Vegetables, melon, pepper, palm oil water. Humans are made from soil, so does vegetables originated from soil, they have affinity for each other and they are made to solve each others problems. Another fact is that, the vegetables, fruits, cereal and other food items when they are grown and ripe they are in problems if they are not eaten, eaten by man, they rotten and fails to fulfill the essence of creation, human being is their solution to their problems, to eat them as at when due, same goes for men who must eat them as food as medicine for man to fulfill the essence of its creation. It is the secret of the nature.

It is quite conceivable that some alternative medicine practitioners are using useful compounds or techniques which are not yet known to Orthodox medicine, researchers and those who make derogatory remarks. This is the skill, this is the secret of our fathers, Ohun ti agbalagba fi n jeko abe ewe lowa - the secret of the survival of our fathers remains sacred. You can not discover this, unless a reasonable provision is made for this practitioners to live a meaningful life like a Nigerian citizens.

No traditional medical practitioner set out to have products to kill, damage the health of his or her clients. But because the Nigerian system of health in the hands of 'acclaimed' Alfa and omega, they labelled the traditional medicine practice with all negatives. Sugbon nitori a ti pa Aja a n soo ni oruko buruku.

Thanks.

HIFA profile: Owolabi Sunday Adebayo is a Health Officer (CHW) with special interest in Herbal medicine at Ilera Eda Herbal World in Nigeria. Professional interests: Trained Community Health Extension Worker, has cert in Health Administration and Mgt and a Bsc in Health Edu. Professional interest in Traditional medicine. I operate a traditional medicine center, produce Herbal medicine.... currently treating patients with High blood pressure, stroke and breast cancer. Email address: oasisofcreative AT yahoo.com

CHWs (131) Introduction: Faith Atai, Uganda

6 July, 2019

My name is Faith Atai. I work as a health inspector at Soroti Municipal Council, Uganda. Currently, am a student at Makerere

University School of Public Health pursuing a bachelors degree in environmental health science. I have directly worked with communities for five years and it's been amazing. While at work, I take part in the implementation of community based public health interventions and also conduct pieces of training of grass root community health workers. The experience overall is thrilling to me because it's a profession I chose to take such that I can make a positive contribution to the communities.

HIFA profile: Faith Atai is a Health Inspector at Soroti Municipality in Uganda. Professional interests: Working with grass root community health workers to protect, preserve and promote health. Email address: ataifaith AT @gmail.com

CHWs (132) Compilation of messages during week 5

6 July, 2019

Dear HIFA colleagues,

Thank you for your contributions to the discussion so far. We are now entering our sixth and final week.

Please find here a compilation of messages during week 5 (27 June to 4 July 2019), with thanks to HIFA volunteer Sam Pakenham-Walsh [http://www.hifa.org/support/members/sam]:

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

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With thanks, Neil

Coordinator, HIFA Project on Community Health Workers

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

Access the CHW Guideline here:

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

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - www.hifa.org), 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 (133) Certification of CHWs (14) Training traditional birth attendants in Nigeria (11)

6 July, 2019

Dear Dr. Joseph, Thank you for the corroboration, and additional guidance. [http://www.hifa.org/dgroups-rss/chws-128-certification-chws-13-new-messa…

Prof. Gawande gave the Reith Lectures in2014 on the theme, The Future of Medicine. Btw, ""traditional Midwives" is the preferred term for these heroic women, whose healthcare skill sets boggle the mind, and who should be recognized globally by healthcare institutions, including UN Agencies, before we have any chance of putting things in proper perspective to the end the neglect of these often despised CHWs that they may enjoy greater self esteem and be enabled to show the formally educated healthcare professionals how they have managed to stand in the gap, despite persecution by their formally trained colleagues.

Through simple measures, love, honesty, humility, one male obstitrition transformed the ambiance of the referral hospital in Karamoja by making patients and their friends and reletatives and children who now feel compfortable when visiting the ANC clinics, due to aligning their methods in maternal and infant healthcare to conform to the local cultures and traditions. And thus ANC stats shot up, with no additional burden to the existent budget. No more abusive certified midwives under this doctor's watch!

And "Obedience commands obedience". That, BTW is how leadersship is born.

When I read your response to my earlier post, I was reminded of one our monthly MCH TWG meetings, sunder the auspices of this East African country’s MoH

First Friday of every month, from 9 AM to 1 PM, beautifully brutally truthful - no BS allowed!

The fomadable Chair or ,moderator kept us on our toes, and it was extremely intense, like a war room; Each of us dedicated defenders of the faith to do the needful to minimize maternal and infant morbidity and mortality, acutely aware, at some deep level of our being, that the pain, the suffering mightbe lessoned by our concerted efforts.

The moderator Th at this meeting was a highly competent compassionate and respected medical doctor aswell as high offical of the ministry.

During one of the mornings presentation by one of the larger healthcare NGOs our chair interrupted her presentation after she quoted one of the official statistics for the percentage of babies born outside of the helthcare system, to remind us that we all knew that the true percentage was probably quite higher. Some whispered that it might be as high as three times as high

This man's honesty, courage and integrity, leading by example put wind in our sails, encouraging us to stay true to the great cause to which we had dedicated ourselves.

In closing, we need to think about the un-remembered and often despised traditional midwives who probably still play a key role in the safe delivery of as much as two thirds of babies born outside the healthcare system,- a system that has for too long neglected to provide sufficient support in proportion to the CHW's contribution tocountry's primtary healthcare needs.

Let's see what we can do advocate for rectifying this neglegence, and put things right.

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HIFA profile: Daniel Stern is a HIFA Representative and member of the mHIFA WG. He is a member of Uganda MCH TWG. Daniel is Co-founder of the educational NGO Uconnect, and of the Innovation Hub, Hive Colab, and is also Cofounder of ISOC Uganda and Uganda IXP. He is a UN WSA National Expert. His Uconnect team distributes off-line E-Learning content, including Hesperian Health Guides to schools in East Africa since 2008. During his six-years as Lead for Uganda Mobile Monday he regularly organized events with mobile health themes, usually in collaboration with UNICEF's Uganda team, and their pan African IntraHealth efforts to improve interoperative healthcare systems, both within and between countries,in mHero, such that developer- entrepreneurs's apps would align with the latest trends by MoH policies.

http://www.hifa.org/support/members/daniel

DStern AT Uconnect.org

CHWs (134) CHWs and mental health (3) Supervision of CHWs

6 July, 2019

Dear HIFA colleagues,

We have discussed the role of CHWs in providing mental health services. This paper looks specifically at methods of supervision of task-shared mental health care, with a focus on Africa. Citation and se;lected extracts below.

CITATION: Supervision of Task-Shared Mental Health Care in Low-Resource Settings: A Commentary on Programmatic Experience

Christopher G. Kemp, Inge Petersen, Arvin Bhana, Deepa Rao

Global Health: Science and Practice,2019

http://www.ghspjournal.org/content/7/2/150

'Task-shared mental health care programs in low-resource settings often incorporate supervisory structures that would be difficult to implement at scale, and many rely on foreign specialist experts as supervisors. Future programs could leverage peer supervision, technology, competency assessments/fidelity checklists, and other tools. Mental health care specialists will require training, support, and incentives to supervise generalist care providers.'

'The relative effectiveness of different supervisory models for task-shared mental health services in low-resource settings remains understudied, although recent calls for research suggest that a change is imminent. Little is known about the range of supervisory models already developed and implemented as part of task-shared mental health care in low-resource settings. An exploration of these models would offer support to future programs as staff plan, design, and implement task-shared programs. Our objectives were to provide an overview of the literature on the supervision of frontline and mental health care workers in low-resource settings, to describe and draw lessons from the experiences of implementers of task-shared mental health services in these settings, and to offer evaluative commentary for consideration by future investigators and implementers.'

OVERVIEW OF SUPERVISION MODELS

Supervision of frontline health care workers — including but not limited to those delivering mental health care — may take many forms. Most broadly, supervision refers to the cyclical process in which a senior professional or team sets expectations for the practice of health care workers at a lower level in the health system, observes and/or audits that practice, assesses whether it meets expectations, and provides guidance or takes corrective action.23 Supervisors employ a wide range of activities to carry out these functions, and health systems may focus on and prioritize some supervisory functions over others. Depending on that focus, models for supervision fall along a spectrum of 3 general categories: traditional supervision, supportive supervision, or mentorship...

One well-documented approach to task-shared mental health supervision—focused specifically on psychosocial treatments—is the apprenticeship model: a collection of training and layered supervision methods originating with researchers at Johns Hopkins University, named after the model used by many crafts and trades. It is distinguished by its inclusion of 3 types of individuals: counselors, supervisors, and trainers.47 Counselors may be any type of mental health service provider, including community members trained to deliver a psychosocial intervention, while supervisors are counselors with the expertise or skills necessary to support other counselors...

We interviewed 16 informants between October 2015 and January 2017. Most were researchers, and most worked in sub-Saharan Africa... Informant experiences reflected 5 broad themes: movement from research to scale-up; building capacity for supervision by specialists; social hierarchies and supportive supervision; technological opportunities; and allowing for context, fluidity, and heterogeneity. We describe each of these below...

Specialists need additional training in supervision and personnel management to manage teams of task-sharing mental health workers...

CONCLUSION

Supervision is an understudied but critical component of task-shared mental health programs in low-resource settings. As interventions move from development to implementation and scale-up, models for supervision that are feasible for dissemination are increasingly being developed. In the absence of adequate numbers of specialists to provide supervision, technological solutions like audio recording and WhatsApp groups supported by supervisor guides and fidelity checklists can help promote better quality supervision as well as contact with supervisees. Further research is

necessary to evaluate models for supervision across different programs and contexts.

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Best wishes, Neil

Coordinator, HIFA Project on Community Health Workers

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

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CHWs (135) Selection of CHWs for pre-service training (16) CHWs with low literacy

7 July, 2019

[in response to Rebecca Furth, USA: http://www.hifa.org/dgroups-rss/chws-125-certification-chws-10]

This is my greatest challenge, in the renew support for CHWs. It is not only leaving those who were trained before behind but how do we ensure the real full engagement of communities when our selection criteria do not fit those they would like or those in the community do not meet the requirements. This is especially significant considering that the main reason they are not selected is because they do not meet the education requirements. During the days long ago when it was promoted that CHWs should use the five essential drugs to prevent mortality at the community level and when all said CHW needed to be literate so they would not give the wrong medication of the five, the famous Dr. Mrs Arole explain to me in working with illiterate women in the CRHP [*see note below], that she did not know of anywhere in the world where women use more flavoring and

spices, etc. in cooking than India, however the illiterate women as these women she worked with were, they never mixed them up and put the wrong spices in a dish. This was just like what she had seen in all the many years of working with them. She had not seen these illiterate women given the wrong medicine to any child. Instead with the appropriate training and supervision use by CRHP, these women had even taken what they learned and applied them in such extraordinary ways that proved to be more effective and were making unimaginable progress in improve health and transforming their communities.

That confirm exactly what I had seen and know now from in all these over 30 years. Like I told those in Liberia, we are saying that because we want things to be easy for us. The burden is on us, highly educated and experts to work together, including with those of us in education and training, to come up with creative ways to trained and supervise illiterate CHWs, a means of getting correct and appropriate data and getting them to use their data for decision making as was done by Dr. Mrs Arole and others at Jamkhed, India. I know there are ways, because I have worked with Traditional midwives for over 30 years and have seen what those illiterate women can do that I would not exchange for literate ones because we the experts cannot come up with appropriate methods to teach and supervise them and obtained the right data that can be used to make appropriate decision. So I would like to challenge us not to have literacy as a criteria for exclusion but rather to be creative and come up with appropriate methods of working with them and benefitting from their expertise in community health as we are all teachers and learners as Jane Valla and my peers in "Dialogue Education" would say or be like the US Ambassador to Liberia says and meet these communities where they are and work with them to where they would like to and should be.

HIFA profile: Marion Subah works for JHPIEGO in Liberia. Marion.Subah AT jhpiego.org

[*Note from HIFA moderator (Neil PW): CRHP = Comprehensive Rural health Project]

CHWs (136) Modalities of pre-service training (4) ANCHUL (AnteNatal and Child Health care in Urban sLums) (2)

7 July, 2019

Excellent resources and thanks for sharing [http://www.hifa.org/dgroups-rss/chws-96-modalities-pre-service-training-…. As It is important that we

as NGOs work with the MOHs to make sure the Ministries policies and guidelines do not conflict with ours and that we are implementing in alignment with the MOH, in Liberia we are now working with the MOH on policies and guidelines at what could be consider urban community health promoters and the guidance in the tool kit, especially on selection, training, supervision, etc. is very good as we discuss integration of large scale programs and institutionalization of Programs with paid CHWs according to the WHO recommendations.

In addition, I am doing an online course on Strengthening Community Health Workers Programs through Harvard University led by Dr. Raj Panjabi of Last Mile Health with many excellent co-presenters, that I would like to recommend to all, especially those like me with much community health experience, who in this forum that do not know about it yet.

HIFA profile: Marion Subah works for JHPIEGO in Liberia. Marion.Subah AT jhpiego.org

CHWs (137) Selection of CHWs for pre-service training (17) CHWs with low literacy (2)

9 July, 2019

Dear All,

Charles Dewah, Marion Subah, Rebecca Furth and a few others have echoed my thoughts about educational qualifications, certification and other aspects of WHO guidelines to formalise the CHWs becoming a part of the mainstream.

I was among those inspired by the work of Aroles and Bangs in rural and tribal areas of India when I was beginning my work in the community to look at Early Childcare and development of children with special needs in the urban slum community. In essence I was trying out something similar, except that the focus was on childhood disability.

Today, after a few years in such settings (resource constrained urban settlements), these are a few of my observations :

1. Communities are not homogeneous. Neither is the nature of community health needs.

2. The factors that influence health in the community are several.

- Often, the determinants at play are not very different from those propounded by Dahlgren-Whitehead. [*1 see note below]

(Pediatricians may also relate to the Bronfenbrenner model of Child Development [*2])

3. CHWs, even when residing in the community, have a limited understanding of health care when not a part of the system and require training, a continued guidance and hand holding support in special projects because of their low levels of literacy.

4. The level of native intelligence is high, they learn quickly on the job, are self-motivated to perform with small incentives (which include acknowledgement of their contribution and respect for their work), in addition to a decent remuneration.

It would be a pity to lose the traditional health workers such as the dais or traditional birth attendants (TBA) on the grounds of education level or not having a recognised certificate. Many of them demonstrate a commitment to community service and possess good interpersonal skills. There is a strong need to have modular training to retain them in the System.

5. Changes over time in the world around the CHWs are not to be ignored.

The younger generation of CHWs do care about certification and career prospects.

They adapt to technology well and can perform better under technology-guided supervision. However, they are quick to make career moves in quest of better financial prospects and this results often in poor experiential learning as well as loss to the community.

Acceptance by target Community also takes a while and a public service ethos can be developed only if there are senior professionals working alongside or mentoring the junior cadres.

Personally, I believe that on-the-job training adds value to the work, irrespective of the curriculum of pre-service training.

6. CHWs may be seen as Community Health aides who are a part of the health team in the Primary care setting and not as replacing other health professionals in the Health Centre. While being valuable human resources for health in all Developing countries, they must not be seen as alternative health work force substituting for the Nurses, therapists, and doctors. They

must be empowered with skills and knowledge to bridge the divide between marginalized, hard- to- reach Communities and inaccessible Health Centres. Hence, the training should be appropriate to the tasks under consideration and certification should also reflect the scope of the training.

Lastly, the time is ripe for us to now explore how global health Communities and local CHW communities can work together to better understand the needs and priorities for Primary Health care in the context of Universal Health Coverage. This may mean prioritising prevention, health promotion, rehabilitation and palliative care as prime areas for CHWs, while encouraging them to play assistive roles for diagnostic and curative services as per the demands in the particular setting.

Thank you.

Best regards,

Sunanda

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

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

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

write2sunanda AT gmail.com

[*Note from HIFA moderator (Neil PW):

1. The Dahlgren-Whitehead rainbow model of socialdeterminants is described here:

https://esrc.ukri.org/about-us/50-years-of-esrc/50-achievements/the-dahl…

2. The Bronfenbrenner model of Child Development is described here:

https://www.firstdiscoverers.co.uk/child-development-theories-urie-bronf…

CHWs (138) Selection of CHWs for pre-service training (18) Remuneration of CHWs and other primary health workers

10 July, 2019

[*Note from HIFA moderator (Neil PW): The message from Massimo below was originally sent off-list and is forwarded with his permission]

Dear Massimo,

You are right [see below] about the need for existing cadres to be remunerated well and taken care of. I am all for it.

It is also true that communities do not pay the salaries to CHW. Often they are paid under projects of non-governmental sector when not part of the Government system.

However, there have been suggestions for village heads to sustain the salaries from the funds allocated to them. We are also advocating for CHWs to form Self helps groups as in Bangla Desh but it may not be easy to sustain in India. ASHAs are there for specific work and many of us have voiced our opinions at various fora that they need to be paid well. It goes without saying that existing cadres at PHCs need to be paid even better. I endorse your view that Health care personnel should all do what they are expected to do, and we should be looking at task sharing and not task shifting.

Let us face it, task shifting is needed only because Health facilities are poorly staffed in the first place. If we need CBR workers in disability related Health Initiatives, it is because of a shortage of rehabilitation professionals; poor urban slum communities cannot afford the costs of transdisciplinary care (early intervention) the children require.

If slim budgets prevent good remuneration for front line workers, will Governments even have the finances to create health infrastructure everywhere to meet the doctor/ nurse- patient ratio better? I believe that it is not an "EITHER- OR" situation. We need both to achieve UHC. Increasing allocation for health in National budgets is a priority and WHO recommendations, I hope, will serve to strengthen political will.

Thanks and best wishes,

Sunanda

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

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Dear Sunanda [re: CHWs (137)], you should add to your points the following

CHWs are nowhere recognized/remunerated by their communities (as it should be - my note).

Formal health workers are already trained, are respected by their communities and above all CAN DO AND SHOULD DO THE SAME WORK EXPECTED FROM CHWs(in capital letters!).

Dear friends in the world, when budgets are slim one should concentrate on what is already in place, support-refresh personnel that already is employed

and NOT create new cadres that wont be able to sustain on the long run. This is the case of CHWs.

Greetings from Dodoma

Massimo

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

CHWs (139) Introduction: Aparna John, UK/India - Anganwadi workers

10 July, 2019

Dear HIFA community,

I'm a researcher who works on Community Health Workers in India. My PhD focused on the drivers of performance of one of the CHW cadres in India: Anganwadi workers [*see note below]. I then worked on a FLW grant by Oxford Policy Management, funded by the Gates foundation synthesizing evidence on the performance of FLWs in India.

I'm keen to network with other researchers who are working on CHWs around the world.

http://www.hifa.org/support/members/aparna

Many thanks,

Aparna John

HIFA profile: Aparna John is a researcher who works on Community Health Workers in India. Her PhD, which she successfully defended early 2018, focused on the drivers of performance of one of the CHW cadres in India: Anganwadi workers. She later worked on a FLW grant by Oxford Policy Management, funded by the Gates Foundation. She is based in Witney, Oxfordshire, UK and is keen to network with others. She is a memmber of the HIFA working group on CHWs. john.aparna AT gmail.com

[*Note from HIFA moderator (Neil PW): 'Anganwadi is a type of rural child care centre in India. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition. Anganwadi means "courtyard shelter" in Indian languages. A typical Anganwadi centre provides basic health care in a village...' https://en.wikipedia.org/wiki/Anganwadi]

CHWs (14) What are your thoughts on the Guideline? (18)

11 July, 2019

Dear HIFA team,

It is with great pleasure I learnt about CHWs empowerment process through initiatives such as WHO training standardization guidelines, as CHWs are key persons in health chain, closest to people & communities.

We just completed second batch training for CHWs part of/serving Garbage city community of Manshiat Nasr, Cairo/Egypt. First batch was trained in 2018. It was a challenging and beautiful project, funded by private donations (individual small contributions).

I am contributing with some comments based on our experience.

As consultant with PCI (Primary Care International), I have submitted same comments to them, so it might come to you from them as well.

Question 1: What are your thoughts on the Guideline? What questions do you have about it?*

Guidelines well needed as reference to good practice and framework for action. Helps in co-building project with local partners and gives framework for handover.

Lacking aspects of training of trainers, with identifying champions who could receive a specific training added to the standard one, for continuity purposes when there are many stakeholders or when project is funded by external body / organization / trainers who will not be present on site after training completion.

In our project, I have trained 2 doctors (out of 3 in the training team) in project management, training skills, presentation & communication, workshop organizational skills using a large range of participative training

techniques. They will be continuing CHW training process in the garbage city community with training other CHWs.

We have also selected 6 CHW from the best trainees (after written & oral assessment based on knowledge and skills) to be running the community center health aspects, and secured some finances for their monthly payment for one year. They will be responsible for delivering health trainings in community and reference for training other CHW.

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

Literacy level should not be a strict criteria.

We discovered few days before exam session that one of the trainees could not read / write and we had to organize a helping person to sit the exam with her. This CHW attended and participated in every session, was receiving same handout without us noticing she could not read. She passed exam and is an asset to the team.

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

Curriculum should be strongly incorporating exemples and situations inspired by the community CHWs are serving in terms of language, cultural Â & religious beliefs/practices, as should training activities be.

Training delivered in CHWs usual work premices helps empowering them in their role and brings an added value & understanding to the whole training process as admin / care providers / members of community might see it happening

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Q4. Recommendation 5 suggests using competency-based formal certification for CHWs who have successfully completed pre-service training.

How does this suggestion relate to current practice in your country/experience? Is it implementable in your country/experience?

Certifying training is must.

In our experience, the certification we delivered after written & oral examination process was in itself a training & empowering process! For many CHWs they had never sit exam before, they went through tough stress management process with fear to fail it and were very proudly holding their certificates during ceremony as it was in majority of cases their first degree ever received. Some brought their husbands or children and were referred as role models.

Another suggestion is to have a ceremony or celebration as must as well, to celebrate completion of training, acknowledging CHWs efforts and empowering them in their community they are serving / belonging to.

A celebration of success was organized with delivering of certificates, and another ceremony was held inviting the whole community to discover the new offer CHWs were providing.

Always good to gather top administrators, doctors, nurses, community members, families with CHWs to help putting some light on their work.

I will try to share comments in the french HIFA group as well, as french is my first language. I would love to be participating in this group.

I am currently living in Cairo, but home base is in Geneva/Switzerland, and be returning there for the summer.

I would be available from June 30th to attend meetings should it be needed for this working group.

I have submitted request to join HIFA (french & English) and am waiting for reply, looking forward to working with the team.

warm regards,

Anbreen

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CHWs (141) CHWs and mental health (4) MEDBOX Mental Health Toolbox

11 July, 2019

Mental Health Knowledge for Action and Prevention

It has been very often read and heard in the last years - the still very impressing statement - that about 450 million people suffer from mental disorders according to estimates given in one of the WHO's World Health Report. The question arising is:

How many more lives will add to this number and what can the Mental Health community do in order to prevent an increase while working together in better solutions for those already living with mental illness? And how can society be empowered to not only protect themselves by working on their own mental well-being, but also extending their listening and empathy to those going through mental illness?

How can stigma be eradicated giving room to understanding and acceptance to those in need of Mental care?

Surprisingly, in a world of on-going exchange of information and resources, still many countries are lacking of an efficient access to Mental Health related knowledge, literature, best practice and guideline resources, and furthermore, the prevention strategies aren't accessible or not even known or included in many policy programs.

On behalf of MEDBOX, today we want to bring up a basic principle that it also applies to the work of achieving Mental Health for all: Knowledge is power and it is through knowledge that both, prevention and action, can flourish in a platform of informed and united communities. What our medical encyclopedia has to offer to the Mental Health community is precisely this; the knowledge needed to empower individuals to prevent, to act and to train others.

Since April 2019 MEDBOX www.medbox.org has available a new MENTAL HEALTH TOOLBOX www.mentalhealthbox.orgwith a huge amount of resources available for mental health professionals, health worker and anyone ready to take heart and join in the arduous but not impossible goal of achieving a better Mental Health Care.

As Didier Demassosso (HIFA country representative for Cameroon) stated in a recent HIFA forum: “Without knowledge on what mental illnesses are what mental health is and how mental health services should be developed to address the continuously growing needs of populations now more interconnected than ever before, would we be ensuring our future with the people needed to manage it?”

Kind regards,

Nazareth Bonilla Pérez
MEDBOX Project Assistant

Sieglinde Mauder
MEDBOX Project Manager

www.medbox.org
www.mentalhealthbox.org

HIFA profile: Sieglinde Mauder is Librarian at the Medical Mission Institute, Würzburg, Germany. She collects and distributes resources on HIV/AIDS, tropical diseases, humanitarian aid, health service management, e-learning for partners in developing countries. sieglinde.mauder AT medmissio.de

CHWs (142) BMJ Global Health: Is quality affordable for community health systems?

11 July, 2019

[Sharing this paper as it may inform the ongoing thematic discussion about CHWs/WHO guideline, thanks MMC]

CITATION: Kumar M B, Madan J J, Aching M M, Limato R, Nima S, Kea A Z, Rex Chikaphupha K, Barasa E, Taegtmeyer M Is quality affordable for community health systems? Costs of integrating quality improvement into close-to-community health programmes in five low-income and middle-income countries BMJ Global Health. 2019

https://gh.bmj.com/content/4/4/e001390

ABSTRACT

Introduction

Countries aspiring to universal health coverage view close-to-community (CTC) providers as a low-cost means of increasing coverage. However, due to lack of coordination and unreliable funding, the quality of large-scale CTC healthcare provision is highly variable and routine data about service quality are not trustworthy. Quality improvement (QI) approaches are a means of addressing these issues, yet neither the costs nor the budget impact of integrating QI approaches into CTC programme costs have been assessed.

Methods

This paper examines the costs and budget impact of integrating QI into existing CTC health programmes in five countries (Ethiopia, Indonesia, Kenya, Malawi, Mozambique) between 2015 and 2017. The intervention involved: (1) QI team formation; (2) Phased training interspersed with supportive supervision; which resulted in (3) QI teams independently collecting and analysing data to conduct QI interventions. Project costs were collected using an ingredients approach from a health systems perspective. Based on project costs, costs of local adoption of the intervention were modelled under three implementation scenarios.

Results

Annualised economic unit costs ranged from $62 in Mozambique to $254 in Ethiopia per CTC provider supervised, driven by the context, type of community health model and the intensity of the intervention. The budget impact of Ministry-led QI for community health is estimated at 0.53% or less of the general government expenditure on health in all countries (and below 0.03% in three of the five countries).

Conclusion

CTC provision is a key component of healthcare delivery in many settings, so QI has huge potential impact. The impact is difficult to establish

conclusively, but as a first step we have provided evidence to assess affordability of QI for community health. Further research is needed to assess whether QI can achieve the level of benefits that would justify the required investment.

Countries represented in the review: Ethiopia, Indonesia, Kenya, Malawi, Mozambique

HIFA profile: Martin Carroll was previously Head of the International Department at the British Medical Association, London UK, and has worked on issues affecting health in LMICs since 2003. He represented the BMA on the HIFA Steering Group from 2008-16 and is now an independent adviser to the group. martin_c63 AT hotmail.com

CHWs (143) Thank you

13 July, 2019

Dear HIFA colleagues,

We are now coming to the end of our first thematic discussion on the CHW Guideline. http://www.hifa.org/news/who-hsg-hifa-collaboration-empowering-community...

We have expressed our thoughts on the Guideline, in particular Recommendations 1 (selection), 2 (length of pre-service training), 3 (competency domains), 4 (modalities), and 5 (certification). And we have had thought-provoking contributions on many other aspects of CHWs.

We have heard the experience of CHW programmes in several countries, including some of the direct experience of CHWs themselves (we would love to hear more).

In the coming days we shall provide you with a compilation of the whole discussion; 'long edit' and 'short edit' versions; and metrics on contributors.

To paraphrase Churchill, this is just 'the end of the beginning' of our work together to promote, explore and implement the CHW Guideline. The World Health Organization has generously sponsored HIFA to continue our work for the coming year (and beyond). Part of our work plan is to implement three thematic discussions, the first of which is now concluding. We are now planning a second thematic discussion to take place later this year. The other part of our work is to encourage and promote sharing of experience, publications, resources on any aspect of CHWs throughout the whole period

of the project. To help us I would like to invite expressions of interest for a volunteer to join the HIFA working group on CHWs as a 'HIFA catalyst'. His/her role would be to keep an eye on the CHW literature and 'community' and notify HIFA of any new developments or publications relevant to CHWs. If you are interested, please contact me: neil@hifa.org

(Note: Sponsorship of HIFA projects/thematic discussions from organisations such as WHO, The Lancet and Elsevier is critical for HIFA's financial viability. If you and your organisation would like to learn more about sponsorship opportunities, please get in touch.)

On behalf of the HIFA project on CHWs I thank everyone who has contributed to this first thematic discussion. I hope you have benefited and learned as much as I have.

Best wishes, Neil

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

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 (144) WHO releases first guideline on digital health interventions (14) Recommendation 7: WHO recommends the use of digital decision support

13 July, 2019

Dear HIFA colleagues,

I would like to invite discussion on Recommendation 7 of the WHO Guideline on Digital Health, launched in April this year.

The full guideline is available here: https://apps.who.int/iris/bitstream/handle/10665/311941/9789241550505-en...

Recommendation 7: WHO recommends the use of digital decision support accessible via mobile devices for community and facility-based health

workers in the context of tasks that are already defined

within the scope of practice for the health worker.

(Recommended only in specific contexts or conditions)

This guideline question specifically explores 'the added value of digital decision support tools available at primary health care levels and accessible to health workers via mobile devices'.

It notes: 'There is limited evidence on the effectiveness of health worker decision support via mobile devices directed to clinical health workers. For the intervention directed to community health

workers, the evidence suggests that this may have positive effects on individuals taking prescribed medication but may make little or no difference to the individuals' overall health status. When

directed to community health workers, decision support may make little or no difference to clients' satisfaction with the information they receive.'

'The qualitative evidence suggests health workers find the intervention useful and reassuring for guiding the delivery of care. However, some health workers perceive algorithms as too prescriptive,

and are concerned that they may lose their clinical competencies by blindly following treatment algorithms. The evidence also suggests that clients find the intervention acceptable and enables health workers to be more thorough when providing care.'

COMMENTS/QUESTIONS (NPW):

1. "WHO recommends the use of digital decision support accessible via mobile devices for community and facility-based health workers". Yes. Can we say more about the typology of decision support tools? What do we know about the impact of specific tools in specific contexts?

2. "in the context of tasks that are already defined within the scope of practice for the health worker". I find this over-restrictive. For me it makes more sense to say something like "with content and format that are reliable and relevant to the practice of the health worker". Such content should include information to recognise health situations that require urgent referral. It is dangerous actively to restrict health workers' knowledge.

3. "For the intervention directed to community health workers..." The focus

on CHWs is interesting. It would be valuable to analyse the rols of digital decision support across different cadres in different clinical contexts.

4. "this may have positive effects on individuals taking prescribed medication" I don't see how decision support for CHWs can promote patients to take medicines.

5. "When directed to community health workers, decision support may make little or no difference to clients' satisfaction with the information they receive.'" Would one expect decision support for CHWs to lead to client satisfaction with the information they receive?

6. "Some health workers perceive algorithms as too prescriptive" There is a difference between finding a specific algorithm too restrictive and a blanket rejection of algorithms. If the former, consideration needs to be given to the content and presentation of the algorithm. If the latter, then the health worker needs better education and training. Also, what is important is whether the algorithm helps the health worker make better decisions. If it doesn't do that, then it needs to be revised accordingly.

I offer the above not as criticism of the Recommendation, but to explore the issues raised.

Best wishes, Neil

Coordinator, mHIFA Project (Mobile Healthcare Information For All)

http://www.hifa.org/projects/mobile-hifa-mhifa

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