Pending Questions from the

MESA FORUM:

Opportunities for implementing and sustaining Community Health Workers in malaria control and prevention

Questions for Margaret Odera

1. **Despite specific funding constraints, is it possible to achieve better results from malaria workers? Most of the malaria vertical programs have remained unchanged due to various factors. Malaria donors often develop specific short-term impact systems that they struggle to sustain.**

   The possibility is quite limited. Funding is crucial for several reasons. With sufficient funding, large groups of people can receive treated nets, and it becomes easier to travel from place to place to provide health education. Adequate funding also allows for regular refresher training for malaria workers. Without adequate funding, it will be challenging to save lives because:

   - Malaria test kits are essential for diagnosis. I have witnessed people dying because malaria was detected too late. The lack of these test kits is a significant barrier to saving lives, as well as to the timely detection and response in the fight against malaria. Malaria can be difficult to detect clinically without testing,

which can lead to severe consequences, including mental health issues associated with the disease.

Long-term funding is key in fighting malaria. Short-term impact systems often yield inconclusive results, which is a major reason why malaria remains a silent killer.

2. **Can you share with us experiences of CHWs in tackling hepatitis as a public health threat in resource limited settings like Somalia?**

   In Kenya, Community Health Workers (CHWs), especially those working with HIV patients, are trained to provide health education on hepatitis B, encouraging people to get tested.

   I've met CHWs from Marsabit County, which neighbours Somalia. Due to stigma and discrimination, discussing diseases can be challenging. In Marsabit, Mandera, and Garissa Counties, the Somali community can access hepatitis B education, testing, and treatment. However, significant efforts are still needed in education, stigma eradication, and improving human resources.

Questions for Lassana M. Jabateh

1. **How to expand and sustain community health worker programs, and if you could share any best practices or strategies that you've found to be successful?**
   Policy level:
   - Develop national policy with strategy plans – Clearly defined goals and objectives
   - Develop national capacity-building plans including the standardized curriculum for all CHWs. Institutionalize the curriculum at the para-medical institutions.
   - Advocate with parliamentarians to have national legislation on community health strategic plans.

   Finances:
   - Develop national costing of the community health program – this will help with advocacy.
   - Develop an advocacy strategy – to guide your engagement with national and international stakeholders.
   - Mobilize communities to provide local motivational support for the CHW in many forms

2. **How do countries raise funds domestically for Community Health Worker (CHW) programs? Could you provide examples of countries that have implemented such strategies and explain how they mobilize funds?**
   - Create a national legislature on how much domestic revenue is directed to support Community Health Worker (CHW) programs.
   - Build the Community Health Worker (CHW) programs focusing on youth and gender inclusion. Work with the Ministries or bureaus responsible for youth and

gender to shoulder the remuneration of the youth and female community health workers.
- Develop national costing of the community health program – this will help with advocacy for funding.

3. **How is Community Health Worker (CHW) data utilized to monitor malaria trends at health facilities, particularly considering that the data is typically reported at the end of each month?**
    - CHWs and their supervisors are attached to the catchment health facilities for reporting, and supervision/mentorship by the facility clinical team.
    - CHW referrals on signs and symptoms of Malaria are reviewed monthly by their supervisors attached to the facility.
    - CHW malaria-treated data are reviewed monthly by their supervisors attached to the facility.
    - CHW Malaria management supplies and medication data are reviewed monthly by their supervisors before restocking.
    - Monthly review of under-five children treated in the community data against the number of children in the catchment.
    - Monthly review of the above and under-five Malaria cases treated at the facility against the total population.

4. **How are Community Health Workers (CHWs) involved in vector control interventions in Liberia?**

    - Train and equip the CHWs on the vector control methods for Malaria.
    - Through door-to-door visits, CHWs sensitize the community on the importance of vector control intervention.
    - The CHWs explain the vector control methods using Job Aids, flyers, and banners and this improves community compliance.
    - The CHWs distribute the flyers and banners with Vector control intervention messages.
    - CHWs use the available Radio airtime to explain the message in the local dialect to a larger audience.

Question for Harriet Napier

1. **Supportive supervision for CHWs poses significant challenges. Have you explored the option of implementing peer-to-peer supportive supervision? This approach is a low-cost intervention that I believe can effectively tackle the cost-related issues.**

    In Cambodia, supervision normally occurs through Village Malaria Workers (VMWs) regular visits to the health facilities. Monthly meetings are hosted by health facilities for VMWs in their catchment area. VMWs travel to the health facilities to deliver their reports, restock, and collect their incentive. These monthly meetings provide VMWs with the opportunity to sit together as a group and discuss challenges and successes

of their work with their supervisors. As shared during the presentation, our latest data indicates that 100% of VMW monthly meetings are taking place with 99% attendance. 85% of VMWs receive incentive payments on the day of the meeting using electronic payment.

In Zimbabwe, Village Health Worker (VHW) supervision is given in the form of VHW meetings and supportive home visits for one-on-one discussions. Facilities hold monthly VHW meetings and keep VHW meeting minutes and conduct home supportive visits monthly or quarterly depending on facility workload. Monthly meetings are also utilized for reporting and refill of commodities. I do not have data to share on VHW meeting or supervision completion rates.

In the DR, CHW supervision is organized into two categories referred to as “direct” and “indirect” supervision. Indirect supervision occurs weekly, when assigned personnel from local level MoH pick up CHW’s weekly performance reports at their homes. This visit allows restock of commodities and gives CHWs the opportunity to address any doubts and bottlenecks. Direct supervision occurs once every two months, where the local level MoH visits each CHW’s home, implements a questionnaire to measure CHW’s malaria knowledge, attitude, and aptitude. This questionnaire includes accompanying the CHWs in their active case detection and supervising their performance of the RDT. Data collected in both direct and indirect supervisions are entered in a data collection platform, SurveyCTO. The weekly data collection is displayed in a dashboard that can be accessed by MoH and NHS personnel.

2. **How about the estimated number of malaria cases? Some countries are reporting only half of the anticipated cases.**

Regarding Cambodia -- Generally no, we’re fairly confident given the high number of tests performed and the consistently high level of reporting we see. Is this question related to the estimated number of cases in the World Malaria Report 2023 (point estimate 17,607 in 2022) vs what the country actually reports (4,053 in 2022)? If so, the difference is due to how WHO estimates the cases. Cambodia falls under “Method 1” in Annex 1, Table 3.1. Global estimated malaria cases and deaths, 2000-2022. The specific figures used for the Cambodian calculation are not shared, but the 2008 WMR, which provides a more in-depth explanation of the methodology, notes that adjustments are made to “take into account the propensity of fever cases to use health facilities not covered by the HMIS (e.g., those going to the private sector), or not to seek treatment at all.” In Cambodia, the private sector is no longer allowed to test and treat for malaria (since 2018) and was where ~65% of patients sought care when they suspected they had malaria in 2013, according to this paper. Given this, it’s likely that the WMR estimation tries to factor this in, resulting in a much higher number of anticipated cases than those reported. Given that we have limited information on how many people are seeking malaria services at the private sector/referral rates, it’s hard to truly say the public health system is fully capturing all cases in the country, but the large VMW network, targeted to areas of higher transmission, likely helps to compensate at least
somewhat for the lack of private sector involvement.

In the Dominican Republic, cases are reported and tracked by multiple entities: local level MoH, by the Malaria program and by the National Surveillance Directorate. The data is validated on a daily and weekly basis. Case under reporting is not perceived as a pertinent issue in the Dominican Republic.

Finally, in Zimbabwe, facility reporting rates are high (around 98% data completeness and timeliness). There is still a need to strengthen data completeness and timelines for CHWs to HF levels, so CHW data integration could be falling short.

3. **It is evident that what's required is funding. Regrettably, countries are hesitant to allocate additional funds. Since 2001 Abuja declaration, the percentage of health budget within national budgets has actually decreased. Who or what will ensure the sustainability of the efforts CHWs are putting in?**

   I feel quite differently about this. From my reading, funding toward CHWs has increased in recent years – both domestic funding and donor contributions. For instance, the Global Fund Results Report 2022 states that "The Global Fund doubled its investment in community health worker systems in the current funding cycle to US$377 million and aims to further increase its investments in this area." According to Chunling Lu et al (2019), 5,298.02 million dollars of development assistance targeted CHW projects between 2007-2017, representing 2.5% of the 9,277.99 million total development assistance for health during this period. The top three donors (GFATM, Canada, USG) provided USD 4,350.08 million (82.1%). SSA received USD 3,717.93 million. Key iCCM/community health funders include: The Global Fund, PEPFAR, USAID, PMI, BMGF, GFF and Africa Frontline First (AFF). We are also seeing exciting examples of countries committing domestic resources towards CHW networks (an exciting recent example being Burkina Faso).

4. **The challenge of providing a dynamic intervention adapted to local realities remains fundamental for the elimination of malaria. But how can we do? What can be the best profile of a community health worker?**

   A fantastic question. In malaria elimination settings, there is a pressing need to adapt CHW models to the local context. There is also an urgency to transition away from vertical (malaria only) CHW programs, which rapidly lose relevance to communities and the overall health system as malaria test positivity rates decline. From a human behavioural standpoint, demand for narrow CHW services (i.e., malaria testing and treatment only) will always reach a ceiling. If we want to propel ourselves past plateaus in progress, we absolutely need to think about more localized models of CHW service design and delivery. In my perspective, this typically starts by understanding (local) community priority needs and adapting the CHW program such that it meets the community 'halfway.'