Scaling Up Community Health Worker-Delivered Interventions for Common Mental Health Disorders

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Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders

PROCEEDINGS

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Dubai Healthcare City, Dubai, United Arab Emirates

June 23 to 25, 2018
## Contents

1 Introduction ................................. 12
   1.1 Workshop objectives ................................................................. 13
   1.2 Organization of the workshop .................................................. 13
   1.3 Organization of the proceedings ............................................. 14

2 Community health worker initiatives, frameworks, and platforms 16
   2.1 Introduction .................................................................................. 16
   2.2 Community health workers and mental health: WHO initiatives .......... 16
      2.2.1 History of the community health worker ................................. 16
      2.2.2 WHO initiatives related to community health workers ............ 16
      2.2.3 Upcoming WHO guidelines for community health workers ....... 18
      2.2.4 Universal health coverage and mental health ....................... 19
      2.2.5 Community platforms and mental health initiatives ............... 20
      2.2.6 Toolkits ................................................................................. 21
   2.3 Community health worker frameworks ....................................... 23
      2.3.1 Care delivery value chain and five spice model ...................... 25
      2.3.2 Building the investment case for community health workers ...... 27
      2.3.3 Applying the 5-SPICE model ................................................. 28
      2.3.4 Ways forward ......................................................................... 29
   2.4 Review of technology and primary care integration ....................... 31
      2.4.1 Healthcare challenges and barriers to UHC ............................ 33
      2.4.2 Reframing primary care ......................................................... 34
      2.4.3 How technology can enable primary care: key principles .......... 35
      2.4.4 Primary care as a platform .................................................... 36

3 Community health worker roles, tasks, and polyvalence 37
   3.1 Introduction .................................................................................. 37
   3.2 Community health worker roles, tasks, and polyvalence: review presentation ................................. 37
      3.2.1 Evidence base for the role of community health workers in mental health ................................................. 38
      3.2.2 Gaps and ways forward .......................................................... 47
      3.2.3 Panel: implementers’ reflections on community health worker roles, tasks, and polyvalence ................................................. 47
   3.3 Working group on community health worker roles, tasks, and polyvalence: first session ............... 53
      3.3.1 Landscaping activity .............................................................. 54
3.3.2 Value chain, activities, and competencies .............................................. 55
3.3.3 Evidence, tools, and resources ................................................................. 56
3.3.4 Common mental disorders versus severe mental illness ....................... 56
3.3.5 Discussion ................................................................................................. 56
3.4 Working group on community health workers roles, tasks, and polyvalence: second session .......................................................... 61
  3.4.1 Description of stages ............................................................................. 62
  3.4.2 What would be good enough to do at each stage ................................. 63
  3.4.3 What should be done at each stage ....................................................... 63
  3.4.4 What not to do at each stage ................................................................. 64
  3.4.5 Financial implications at different stages ............................................. 65

4 Community health worker recruitment, training, and supervision .................................................. 66
  4.1 Introduction ................................................................................................. 66
  4.2 Lessons learned from training and supervising non-specialist providers: review presentation ........................................................................... 66
    4.2.1 Review of psychological treatments for common mental disorders in low-and middle-income countries ................................................. 66
    4.2.2 Therapy quality and competence ......................................................... 68
    4.2.3 Conclusions ........................................................................................... 74
  4.3 Panel: implementers’ experiences in community health worker recruit ment, training, and supervision ................................................................... 74
  4.4 Working group on community health worker recruitment, training, and supervision: first session ............................................................ 78
    4.4.1 Taxonomy of community health worker characteristics ...................... 78
    4.4.2 Scalable community health worker training models ................................ 79
    4.4.3 Assuring quality of care for common mental disorders .......................... 80
    4.4.4 Role of digital platforms ...................................................................... 81
    4.4.5 Discussion ............................................................................................ 81
  4.5 Working group on community health worker recruitment, training, and supervision: second session ........................................................... 85
    4.5.1 Dos and don’ts for recruiting, training, and supervising community health workers ...................................................................................... 86
    4.5.2 Discussion ............................................................................................ 88

5 Systems and strategies for integration .................................................................................. 93
  5.1 Introduction ................................................................................................. 93
  5.2 Systems-level strategies for community health worker integration into routine primary health care platforms: review presentation ......................... 93
    5.2.1 Incorporating an integrated package ..................................................... 94
5.2.2 Rural health model of collaborative mental health care ........................................ 95
5.2.3 Strategies for integration ........................................................................................ 96

5.3 Panel: implementers’ reflections on systems and strategies for integration................................................................. 97

5.4 Working group on systems and strategies for integration: first session 102
5.4.1 Process of scaling up ................................................................................................. 102
5.4.2 Support, supervision, and referral systems ............................................................. 103
5.4.3 Concepts ...................................................................................................................... 103
5.4.4 Crosscutting issues .................................................................................................. 105
5.4.5 Technology ................................................................................................................. 105
5.4.6 Discussion ................................................................................................................. 105

5.5 Working group on systems and strategies for integration: second session ............................................................................................................................ 110
5.5.1 Key principles underpinning systems and strategies for integration ... 110
5.5.2 Community health workers within the framework of health system building blocks ................................................................. 112
5.5.3 Process for setting short- and long-term goals with existing resources ......................................................................................... 114
5.5.4 Strengthening public sector health delivery systems with community health workers ........................................................................................................ 115
5.5.5 Embedding the mental health care value chain for common mental disorders within the existing mental health system of care .................. 116
5.5.6 Considerations for local- and national-level governance ........................................ 117
5.5.7 Discussion ................................................................................................................. 118

6 Stakeholder and community engagement for taking interventions to scale 120
6.1 Introduction ................................................................................................................... 120

6.2 Stakeholders and community engagement for scaling up interventions for common mental disorders: review presentation........ 120
6.2.1 Landscape of the health system in Lebanon .......................................................... 120
6.2.2 Stakeholder engagement in Lebanon ....................................................................... 121

6.3 Panel: implementers’ experiences in community engagement for scaling up interventions ................................................................................................................. 123

6.4 Working group on stakeholder and community engagement for scaling up interventions: first session ................................................................. 128
6.4.1 Identifying potential stakeholders ........................................................................... 128
6.4.2 Key components of sustaining effective engagement ............................................ 128
6.4.3 Levels of stakeholder engagement .......................................................................... 129
6.4.4 Discussion ................................................................................................................. 129
6.5 Working group on stakeholder and community engagement for scaling up interventions: second session

7 Measurement of Impact

7.1 Introduction

7.2 Measurement of impact: review presentation

7.2.1 Roadmap to impact

7.2.2 Evaluating the pathway to care

7.2.3 Multiple evaluation methods

7.2.4 Evaluating community proactive case detection

7.2.5 Evaluating interventions by community counselors

7.2.6 Evaluating competencies of service providers

7.2.7 Using indicators for routine monitoring of mental health care

7.3 Panel: implementers’ experiences in measurement of impact

7.4 Working group on measurement of impact: first session

7.4.1 Establishing the goal

7.4.2 Structure of the framework

7.4.3 Discussion

7.5 Working group on measurement of impact: second session

7.5.1 Coverage

7.5.2 Quality

7.5.3 Individual-level outcomes

7.5.4 Process indicators

7.5.5 General guidance

8 Reflections and ways forward

8.1 Discussion

8.1.1 Structure of the guidance

8.1.2 Focus of the guidance and frameworks

8.1.3 Community health worker roles

8.1.4 More input needed for recommendations

8.2 Final panel

8.2.1 Focus on community health workers

8.2.2 Sketching a concept- or task-based framework

8.2.3 Delivery of psychological treatments by community health workers

8.2.4 Engaging with all relevant stakeholders

8.3 Concluding remarks

9 References
Appendices

Appendix 1. Mapping skills packages onto existing systems ......................... 170
Appendix 2. Developing care pathways for priority conditions .................... 171
Appendix 3. Workshop Agenda ..................................................................... 172
Appendix 4. Workshop guidance ................................................................. 181
Appendix 5. Working group participants ..................................................... 184
Appendix 6. Participant biographies ............................................................. 185
**Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
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<tr>
<td>ASHA</td>
<td>Accredited social health activists</td>
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<td>AUD</td>
<td>Alcohol use disorder</td>
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<tr>
<td>BRAC</td>
<td>Building Resources Across Communities</td>
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<td>CAP</td>
<td>Counseling for Alcohol Problems</td>
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<td>CES</td>
<td>Compañeros en Salud</td>
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<td>CHR</td>
<td>Community Health Representative</td>
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<td>CHW</td>
<td>Community health worker</td>
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<td>CIDT</td>
<td>Community Informant Detection Tool</td>
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<td>CIT</td>
<td>Crisis Intervention Team</td>
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<td>CMD</td>
<td>Common mental disorders</td>
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<td>COPC</td>
<td>Community Oriented Primary Health Care</td>
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<td>COPE</td>
<td>Community Outreach and Patient Empowerment</td>
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<td>CQI</td>
<td>Continuous quality improvement</td>
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<td>DIME</td>
<td>Design, Implementation, Monitoring and Evaluation</td>
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<td>EDL</td>
<td>Essential Drug List</td>
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<td>HAP</td>
<td>Healthy Activity Programme</td>
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<td>HIS</td>
<td>Health information systems</td>
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<td>Health and medical information systems</td>
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<td>HMS</td>
<td>Harvard Medical School</td>
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<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
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<td>ICF</td>
<td>International Classification for Functionality</td>
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<td>ICCM</td>
<td>Integrated community case management</td>
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<td>IHDC</td>
<td>Institute for Health and Development Communication</td>
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<td>IHI</td>
<td>Institute for Healthcare Improvement</td>
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<tr>
<td>IMCI</td>
<td>Integrated management of childhood illnesses</td>
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<td>KPI</td>
<td>Key performance indicators</td>
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<td>LMIC</td>
<td>Low- and middle-income countries</td>
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<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<td>MEQ</td>
<td>Monitoring and Evaluation and Quality</td>
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<td>MhINT</td>
<td>Mental Health Integration</td>
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<td>MHPSS</td>
<td>Mental Health and Psychosocial Support</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<td>NSP</td>
<td>Non-specialist providers</td>
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<tr>
<td>SDG</td>
<td>Sustainable development goals</td>
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<td>SMI</td>
<td>Severe mental illnesses</td>
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<tr>
<td>TOT</td>
<td>Trainer of trainers</td>
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<td>TPO</td>
<td>Transcultural Psychosocial Organization</td>
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<tr>
<td>TQS</td>
<td>Therapy Quality Scale</td>
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<tr>
<td>UHC</td>
<td>Universal health care</td>
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Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders Workshop, Dubai, UAE

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1 Introduction

Between June 23 and June 25 2018, a group of international experts convened at the Harvard Medical School Center for Global Health Delivery–Dubai for the workshop **Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders**. The meeting was organized by members of the Department of Global Health and Social Medicine at Harvard Medical School, mobilizing a collaboration between a new initiative, GlobalMentalHealth@Harvard, and the nongovernmental organizations Partners In Health and Sangath, with support from the Center for Global Health Delivery (see Box 11 for a description of the Center’s activities).

**Box 1. Harvard Medical School Center for Global Health Delivery–Dubai**

Salmaan Keshavjee, the director of the Center and a professor of global health and social medicine at Harvard Medical School, offered a brief overview of the work ongoing at the Harvard Medical School Center for Global Health Delivery–Dubai. The Center was established to promote the mission of Harvard Medical School: to create and nurture a diverse community of the best people committed to leadership in alleviating human suffering caused by disease. Specifically, the Center concentrates on the “last-mile” of healthcare delivery by addressing critical gaps in translating laboratory and clinical scientific advances into knowledge among communities. Work carried out by the Center contributes to closing those gaps with its focus on delivering care for health conditions with burdens that are mounting rapidly worldwide, but which are not receiving the urgent attention from the global health community that they so increasingly warrant. To strengthen delivery of care, the Center’s cooperative and faculty research awards program is a mechanism to support areas that may not have a culture of research, as well as hosting workshops, symposia, and courses toward creating an ecosystem of scholars in global health delivery. Knowledge and innovation are captured and disseminated through outputs such as proceedings and policy briefs that are driving action worldwide.

Mental health is one of the Center’s key areas of focus, said Keshavjee. According to WHO’s Mental Health Atlas (2014), the Eastern Mediterranean region has a very low number of mental health professionals—estimated to be less than 10 per 100,000 people—despite mental health issues representing the largest burden of disease. Adherence to mental health treatment is very poor due to the lack of systems to support treatment compliance. Forty years after the Alma-Ata Declaration, which underscored the importance of mental health, people around the world do not have access to good mental health care. Investment in health systems strengthening is urgently needed to rectify this by finding ways to deliver mental health care in ways that are integrated into the communities where people live and work.

*(Source: Keshavjee, Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018.)*
1.1 WORKSHOP OBJECTIVES
The aim of the workshop was to synthesize implementation evidence and front-line experiences on interventions delivered by community health workers (CHW) for common mental disorders (CMD). The specific objectives were to inform pathways to scale of these interventions by defining:

- The roles played by CHWs, and other non-specialized providers, including in community and primary care platforms;
- The recruitment, training and supervision arrangements of these providers;
- The systems-level strategies needed for integration of these providers into routine primary care platforms;
- The use of technology to facilitate these roles and strategies; and
- The evaluation of the scaling up of CHW-delivered interventions (methods and outcomes).

1.2 ORGANIZATION OF THE WORKSHOP
The three-day workshop blended short didactics, panels, and working group breakouts facilitated by global experts and boots-on-the-ground implementers. Over the course of the workshop, group discussions and consensus-building on challenges and best practices were designed to contribute to the development of multiple potential outputs, including workshop proceedings, a journal publication, and a white paper consensus statement.

Workshop participants were selected from a variety of contexts to participate in a lively, structured discussion with the aim of developing a shared framework for delivery of mental health care for CMDs by CHWs. The meeting was a confidential discussion among global experts, with intellectual ownership for the workshop outputs to be equally shared. Care was taken to eliminate barriers between “global experts” and boots-on-the-ground implementers.

The meeting featured presentations, panels, small working group sessions, and facilitated discussion by the group at large. Participants broke into working groups to develop operational guidelines for implementation steps in scaling up a community mental health delivery value chain. The five working group themes were:

- CHW roles, tasks, and polyvalence
- CHW recruitment, training, and supervision
- Systems and strategies for integration
- Stakeholder and community engagement for taking interventions to scale
- Measurement of impact

A core assumption for the meeting was that most participants were already familiar with: challenges to scale from experience; tasks, competencies, and organizational/systems features of community-based models; information technology and data science input to inform roll-out and monitoring and evaluation; and challenges to effective systems engineering and continuous process improvement. Thus, the workshop was designed to focus primarily on working actively toward a shared agreement on the various components of a successful community-based mental model that can be replicated across contexts.

On Day 1 of the workshop, the first session featured presentations by global primary care experts with a focus on synthesizing implementation science and front-line experience on the strategies for scaling up CHW-delivered interventions for the care of CMDs. This was followed by five panels corresponding to each of the working group themes. Each panel opened with a review presentation on the topic, followed by a panelists’ reflections of their experiences in that domain.

During Day 2 of the workshop, participants broke into their working groups for the first of two small-group sessions. Participants reconvened as a large group in the afternoon,
when leaders from each working group made a brief presentation about their group's discussion that was followed by input from the large group. Each working group was provided with a set of questions to guide the small-group discussions (see Appendix 4). Because the workshop was designed to be highly interactive, the groups' deliberations were wide-ranging; the suggestions and recommendations highlighted by group leaders during the report-outs were not necessarily restricted to the specific questions and topics provided in the guidance.

The working groups met again on Day 3 of the workshop to refine their ideas based on the large-group discussions. In the afternoon, group leaders again presented their group's work for further feedback from the large group. The workshop concluded with another large-group discussion and reflections from a final panel of expertise to further articulate the core elements of shared practices and systems design for mental health care delivery by CHW for CMDs.

It is important to note that implementers from Partners In Health and researchers from academia were heavily represented at the workshop, which may affect the generalizability of the suggestions made during the working groups and large-group discussions.

1.3 ORGANIZATION OF THE PROCEEDINGS

The proceedings of the workshop are organized into eight chapters. Opening remarks and the charge to participants are summarized in Box 12. Chapter 2 describes presentations on WHO initiatives related to CHWs and mental health, an overview of CHW frameworks that traces the history of the CHW, and a review of technology and primary care integration with reference to the potential role of CHWs. Subsequent chapters contain summaries of the workshop content related to CHW roles, tasks, and polyvalence (Chapter 3), CHW recruitment, training, and supervision (Chapter 4), systems and strategies for integration (Chapter 5), community and stakeholder engagement for scaling up (Chapter 6), and measurement of impact (Chapter 7). An overview of the final group discussion and panel from the last session of the workshop is provided in Chapter 8.
Box 2. Opening remarks and charge to workshop participants

Opening remarks were delivered by Vikram Patel, The Pershing Square Professor of Global Health and Wellcome Trust Principal Research Fellow at the Harvard Medical School. Patel welcomed the impressive gathering of clinical scientists, public health practitioners, and implementers working both in real world and research contexts. He thanked participants for accepting the charge to help improve access to mental health care writ large, but particularly access to interventions for depressive-, anxiety-, and trauma-related common mental disorders. He asked the group to use their expertise and rich experiences to generate recommendations about how practice-based evidence, coupled with evidence-based practice, can be used to scale up CMD interventions delivered by community health worker and non-specialists.

Patel set the stage by emphasizing that these recommendations are extraordinarily timely, given that mental health is fast approaching the crest of an important moment in its history. The field of global mental health is at an inflection point, comparable to what was seen in 2001 with HIV/AIDS, at which there is a moral case to be made for the transition from gathering evidence about what could be done to taking meaningful action to implement that evidence. He noted that in 2018, the UK government will host a high-level summit led by the prime ministers of the UK, Canada, and Australia to bring together 50 heads of state to call for “mental health equity”—that is, equity in the response of public health care systems to the needs of people with mental disorders. The Qatari government will host a major summit in 2018 that prioritizes depression and anxiety. The Lancet will publish a major new commission on global mental health and sustainable development in 2018 and the UN Secretary General announced that mental health will be one of the signature themes of his presidency of the UN. Given this confluence of major events in a single year, Patel said, it is incumbent upon the field of global mental health to expedite the development of clear, specific directions and recommendations about how science and on-the-ground experiences can be translated into scaling up interventions worldwide.

The workshop is part of a much larger new initiative called Global Mental Health at Harvard, launched in April 2018, said Patel. The aim of the initiative is first and foremost to catalyze innovation within diverse groups working in mental health at the university, including the World Mental Health Survey Group and the university’s longstanding history of collaboration with Partners In Health. The goal is to connect with existing partners and to establish new partners to work collaboratively to implement some of the science in the real world. The initiative intends to produce working papers and one of the planned outputs of the workshop is a paper jointly published with the Center for Global Health Delivery on key recommendations that arise.

Source: Patel, Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018.
2 Community health worker initiatives, frameworks, and platforms

2.1 INTRODUCTION

Chapter 2 surveys the landscape of community health worker initiatives, frameworks, and platforms. It features summaries of presentations on WHO initiatives related to community health workers (CHW) and mental health, an overview of CHW frameworks that traces the history of the CHW, and a review of technology and primary care integration with reference to the potential role of CHWs.

2.2 COMMUNITY HEALTH WORKERS AND MENTAL HEALTH: WHO INITIATIVES

An overview of WHO initiatives related to CHWs and mental health was provided by Tarun Dua, a programme manager in the Department of Mental Health and Substance Abuse at WHO. She leads the implementation of mental health Gap Action Programme and is the focal point for brain health in the organization. In addition, she provides programmatic support to the monitoring of the Comprehensive Mental Health Action Plan and is one of the editors for the third edition of the Disease Control Priorities in Developing Countries volume on mental, neurological and substance use disorders. Her presentation covered WHO’s approach to community health, the mandate in the era of sustainable development goals (SDGs) and universal health care (UHC), as well as community platforms and mental health initiatives.

2.2.1 History of the community health worker

Dua began with a description of the CHWs written in 1987, noting that the same issues are still being discussed 30 years later. At the time, few countries had attained wide service coverage, with services/health workers being available only in urban areas and hospitals absorbing large shares of budgets compared to primary health care. A primary health care approach utilizing CHWs was needed to extend services to where people live and work, support communities in identifying their needs, and help people to solve their own health problems. Dua then traced the history of the CHW through the 1970s and 1980s. In 1974, WHO published the document Training and Utilization of Village Health Workers. The Alma-Ata catalyzed new thinking around the primary health worker and led to the publication The Primary Health Worker. This book was edited and revised to develop The Community Health Worker, a document that includes guidelines for training and adaptation, as well as units on curative services, promotive services, and mental health. “What happened was clear integration into systems and making things different,” she said. “What we are talking about now is not something new. It is about the new take that needs to be employed.”

2.2.2 WHO initiatives related to community health workers

Dua explained that in the years since, there have been a host of WHO initiatives related to community health or community health workers across different programs, including disease-specific community models followed by integrated disease control programs that have been helpful in decreasing mortality in various areas. The WHO Global Strategy on
Human Resources for Health: Workforce 2030 encourages countries to adopt a diverse, sustainable skills mix, harnessing the potential of community-based and mid-level health workers in inter-professional primary care teams. The Global Health Workforce Network operates within WHO as a global mechanism for stakeholder consultation, dialogue, and coordination on comprehensive and coherent health workforce policies in support of the implementation of the Global Strategy on Human Resources for Health. The CHW thematic hub aims to promote awareness, ownership, dissemination and use of the emerging WHO guidelines on health policy and system support for community-based health workers.

2.2.2.1 Global Experience of Community Health Workers for Delivery of Health-Related Millennium Development Goals: A Systematic Review

Dua explained that the Global Experience of Community Health Workers for Delivery of Health-Related Millennium Development Goals: A Systematic Review, published in 2010, includes country case studies and recommendations for integration into national health systems. Recommendations related to planning, production, and deployment are that CHWs should be coherently inserted in the wider health system, and this cadre should be explicitly included within the strategic planning for human resources for health at country and local level. The pre-service training curriculum should include scientific knowledge about preventive and basic curative care. In the context of attraction and retention, the recommendations are that village health committees in the community should contribute to participatory selection processes of CHWs and that CHW programs should continually assess community health needs and demographics. With respect to performance management, the review recommends that CHWs should have established referral protocols with formal health services and social service agencies and that CHWs should benefit from regular and continuous supportive supervision and monitoring. She noted that although these recommendations were made during the Millennium Development Goal era, recommendations made today during the SDG era would likely be quite similar. For people working in the field, the critical concerns are around how these recommendations are implemented and how to attract investments into these systems.

The systematic review also identified a set of knowledge gaps, including:

- Information on cost effectiveness
- Role of CHW programs in promoting equity and access
- Effectiveness of paid workers versus voluntary workers
- Effectiveness of different models of remuneration, payment, and incentivization of CHWs across different tasks and settings
- Evaluation of quality of care and effectiveness of health care provided by CHWs as compared to professional health care providers
- Linkage to the wider health system (for example, in terms of referrals and supervision)
- Effectiveness of different approaches to ensure program sustainability

She noted that many of those gaps persist in 2018, such as program cost-effectiveness and the role of CHWs in promoting equity and access, although some evidence has been generated in the other areas. Key research gaps must be identified in mental health, particularly those related to sustainability, scale up, and equity across multiple countries.

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6 World Health Organization 2016
8 Bhutta et al 2010
2.2.2.2 Sustainable Development Goal 3

Sustainable Development Goal 3—to ensure healthy lives and promote wellbeing for all ages—includes a target about promoting mental health and wellbeing: reduce by one-third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and wellbeing by 2030 (Target 3.4). Two other targets are relevant to discussions about CHWs, she noted. Lessons or recommendations related to those targets will be broadly relevant to many of the other areas linked to common mental disorders, such as chronic diseases and noncommunicable diseases.

2.2.3 Upcoming WHO guidelines for community health workers

Dua reported that WHO has created a new guideline on health policy and system support to optimize community health worker programmes, in order to help drive the necessary paradigm shift to address the burdens of mental health and chronic diseases (see Box 3).

Box 3. Forthcoming WHO guidelines for community health workers

Dua provided an overview of the recently released WHO guidelines for CHWs in general, which are not specific to mental health. The guidelines include health policy and system support to optimize community health worker programs, such as:

- **Selecting** CHWs for pre-service education considering minimum education levels appropriate to the tasks to be performed; membership of and acceptance by the local community; promotion of gender equity; personal attributes and capacity of the candidates.

- **Determining duration of pre-service training** in the local context based on scope of work, and anticipated responsibilities and role; competencies required; pre-existing knowledge and skills; social, economic and geographical circumstances of trainees; institutional capacity to provide the training; expected conditions of practice.

- **Competencies in curriculum for pre-service training** including promotive and preventive services, diagnostic and curative services where relevant; interpersonal and community mobilization skills; integration within the wider health care system in relation to the range of tasks to be performed in accordance with CHW role; social and environmental determinants of health.

- **Modalities of pre-service training** including balancing theoretical and practical training, and blending face-to-face and e-learning where feasible, with adequate attention to a positive training environment and faculty.

- **Using competency-based formal certification** for CHWs who have successfully completed pre-service training to improve CHW quality of care, motivation and employment prospects.

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9 Target 3.8 - Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all; Target 3.3 - Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states

10 The WHO guideline on health policy and system support to optimize community health worker programmes is available at http://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1&ua=1 (accessed January 2, 2019)

11 World Health Organization 2018b
Dua commented that as the evidence was being reviewed for the recommendations, it was clear that evidence is limited and is sometimes low quality. “Given that the recommendations are not disease-specific,” she said, “it is important to think about how they can be operationalized in mental health—not only for common mental disorders, but also for severe mental disorders and across the spectrum of promotion of mental health, prevention of mental health problems as well as their management.” Questions to consider include the threshold for adequate support supervision, training requirements, determining the target population size for mental health, and what the engagement of community models might look like in practice.

2.2.4 Universal health coverage and mental health

The UHC umbrella depicts health care needs across the life course (see Figure 1). Dua highlighted the need to explore how community platforms fit across the life course and how they link to all the levels of care for mental health. Outreach services, first-level care, and certain social determinants need to be taken into account, she said. Forty years on from the Alma-Ata Declaration, another global primary health care conference will be held in Astana, Kazakhstan in October 2018, aligned to the implementation of the SDGs. It will include a session on mental health in keeping with WHO’s current renewed focus on countries and measuring impact. “The aim of WHO’s General Programme of Work 13 are the ‘triple billion’ goals,” Dua said: for one billion more people to enjoy better health and wellbeing; for one billion more people to be better protected from health emergencies; and for one billion more people to benefit from UHC. Mental health and community health are part of all the triple billion goals, she added, which is a priority for WHO.

Figure 1. The Universal Health Care umbrella

Source: Dua, Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018.
2.2.5 Community platforms and mental health initiatives

2.2.5.3 Mental Health Action Plan 2013-2020

WHO has been looking at the community platform for mental health, said Dua. She noted that 2001 was a watershed year for mental health, with the release of the World Mental Health Report with the slogan “no health without mental health.” A subsequent watershed moment took place in 2013, with the passing of the comprehensive Mental Health Action Plan (2013-2020) that was developed in the intervening 12 years. Its objectives are:

- To strengthen effective leadership and governance for mental health
- To provide comprehensive, integrated and responsive mental health and social care services in community-based settings
- To implement strategies for promotion and prevention in mental health
- To strengthen information systems, evidence and research for mental health

Progress has been gaining momentum since, with the 2017 World Health Day on Depression and the upcoming Mental Health Summit.

2.2.5.4 Platforms for Intervention Delivery (Disease Control Priorities 3)

Dua explained that within the Disease Control Priorities (Third Edition) volume on Mental, Neurological, and Substance Use Disorders, community platforms were considered across mental, neurological, and substance use disorders and other categories as a useful way of thinking about the different types of resources available within the community. In the context of structuring interventions, for example, key considerations include how CHWs are integrated in these community platforms as well as how CHWs are linked to the population platform. Platforms for intervention delivery included in the volume include:

- Population platform
  - Awareness campaigns to increase mental health literacy and address stigma and discrimination
  - Legislation on protection of human rights of persons affected by mental, neurological, and substance use disorders
- Community platform
  - Training of gatekeepers (community workers, police, teachers)
  - Identification of priority disorders, provision of low-intensity psychosocial support, and referral pathways
- Self-help and support groups (for example, for alcohol use disorders, epilepsy, parents of children with developmental disorders, and survivors of suicide)
- Health care platforms

2.2.5.5 WHO’s Mental Health GAP Action Programme

WHO’s Mental Health Gap (mhGAP) Action Program is another useful resource, said Dua. Although the intervention guide is not for community health workers, but for doctors and nurses, the operations manual does cover treatment and care in the community, including the tools necessary for preparing, implementing, monitoring and evaluating mhGAP.

2.2.5.6 Scalable psychological interventions for people in communities affected by adversity

Dua noted that much more work has been carried out in the area of psychological interventions. In 2017, WHO released the document Scalable Psychological Interventions for People in Communities Affected by Adversity: a New Area of Mental Health Care.
The document summarizes: selection of implementation platform and psychological intervention; translation and adaptation; identification, assessment and referral; training; supervision and quality assurance; and monitoring and evaluation. It links to ongoing work and guidance being developed by WHO in relation to scaling up CMD interventions through delivery by CHWs.

2.2.5.7 Ensuring Quality in Psychological Support
WHO has a new project aimed at Ensuring Quality in Psychological Support (EQUIP) through a psychological intervention workforce development package. Dua noted that its elements in the development package on scalability and competency of the workforce are related to the use of CHWs to deliver care for CMDs.

2.2.6 Toolkits

2.2.6.8 Quality Rights Toolkit
As part of the QualityRights Initiative, WHO has developed a comprehensive package of training and guidance modules. It includes one to provide guidance on how to build and strengthen peer support groups for and by people with psychosocial, intellectual and cognitive disabilities and also groups for and by families and/or care partners. The Quality Rights Toolkit\(^\text{16}\) provides countries with practical information and tools for assessing and improving quality and human rights standards in mental health and social care facilities.

2.2.6.9 Disease-specific toolkits for community health workers
Other disease-specific guidance is available to support CHWs, said Dua, such as the WHO Caregiver Skills Training for Families of Children with Developmental Disorders or Delays. This universal caregiver skills training package is being implemented in more than 30 countries. She suggested looking at some of these interventions and how they could be scaled up using community resources. Similar toolkits are available for dementia\(^\text{17}\) and epilepsy.

2.2.6.10 mhGAP Community Toolkit
Dua used the mhGAP community toolkit\(^\text{18}\) to explain how resources can be brought together across settings, platforms, and sectors. The mhGAP toolkit characterizes the community platform as encompassing efforts to bring health care services to clients—that is, meeting people where they live. It broadens the definition of the community platform for delivery of health care services to include non-health care settings and individuals, requiring strong intersectoral engagement across a variety of sub-platforms, delivery mechanisms, and delivery agents. The dimensions of community mental health include:

- Community platform settings: neighborhood and community groups, schools, workplaces, welfare/social sectors, and community health settings.
- Community providers: CHWs, non-healthcare workers, formal providers, and informal providers
- Spectrum of interventions: mental health promotion/prevention, awareness and identification, and treatment/support.

Figure 2 is a schematic of the mhGAP community toolkit framework and roadmap. It spans the gamut of providers (including faith and traditional healers), sub-platforms, and interventions that must be brought together. It covers needs assessment, availability of resources, activities required, and overarching objectives.

\(^{15}\) World Health Organization 2017
\(^{17}\) World Health Organization 2018a
Figure 2. mhGAP community toolkit framework (top) and roadmap (bottom)

Source: Dua. Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018.
2.3 COMMUNITY HEALTH WORKER FRAMEWORKS

Frameworks that can be used to help ground community health worker platforms were surveyed by Dan Palazuelos, associate physician in the Department of Medicine, assistant director of the Hiatt Global Health Equity Residency in the Division of Global Health Equity, clinician-educator hospitalist at Brigham and Women’s Hospital, Assistant Professor and Cannon Society Global Health Teaching Fellow at Harvard Medical School, director for community health systems at Partners In Health, and cofounder/chief strategist of Compañeros En Salud - México (PIH-Mexico).

Palazuelos sketched the history of the concept of the community health worker. While its origin remains difficult to pinpoint, the concept is inextricably linked to colonialism. To illustrate some of the resultant tensions that persist today, he recounted the example of the barefoot doctors of China. During the middle of the 20th century, Mao Zedong could not persuade Soviet-trained doctors to work in the rural areas where the vast majority of the population resided, of whom ten million were infected with schistosomiasis—a disease caused by parasitic worms that live in snails that inhabit swamps and rivers. As part of China’s medical reform, a massive public health campaign was enacted whereby hundreds of thousands of local people worked to eliminate the snails’ aquatic habitats (e.g., by building drainage ditches and draining swamps). The efforts drove a steep decline in infection rates in areas where schistosomiasis had previously been endemic. Based on the success of the campaign, thousands of young people were provided with 3-6 months of intensive rudimentary medical training to provide basic health care in rural areas. The number of these “barefoot doctors” eventually reached hundreds of thousands, with many of the barefoot doctors going on to become fully trained doctors. Although the program ultimately collapsed by the 1990s, it has been credited with increasing live expectancy in China dramatically.

Similar movements were ongoing in the West during the same period, catalyzed by WHO and others. For example, in the 1960s, a manual named “Where There Is No Doctor” was developed for delivering care door-to-door in rural areas where health services were otherwise non-existent, premised on the idea that lay people can be trained to do what doctors do, such as injecting penicillin and diagnosing strep throat. This ethos was a revolutionary thought that underpinned many revolutions in Latin America: “MDs should not be on top, but on tap.” In a classic talk, David Werner asked whether community health workers are liberating communities or serving as lackeys for the system—doing things in lieu of doctors just because the doctors cannot get to rural areas (see Figure 3). This is one of the core tensions to be reflected on, maintained Palazuelos.

19 Valentine 2005
20 Palazuelos 2018
In 1979, Welsh and Warren\textsuperscript{21} suggested implementing selective primary health care, which Palazuelos said was constructed to be the only feasible option at the time. Leaders such as Jim Grant helped to raise money to support a basic package of services to create a child survival revolution, which was successful but also skewed the conversation: the focus of discussion shifted from universality to “at least the kids.” At the same time, social safety nets were being ripped apart and vulnerability was increasing. That vulnerability directly contributed to the HIV epidemic and then with many activists pushing forward, antiretrovirals were eventually available for the poor and vulnerable. Then a new community health worker model was revitalized with the idea of treatment support (i.e., an accompaniment function) to address challenges with treatment adherence. This accompaniment model has been applied across PIH and elsewhere. In a project in Mexico, PIH applied the model to noncommunicable diseases (NCDs) and found a two-fold increase of the odds of adherence to treatments for diabetes and hypertension sustained across two years.

Palazuelos explained that integrated management of childhood illnesses (IMCI) is the dominant model. In IMCI, community health workers doing a selective package are usually treating three things: malaria, pneumonia or diarrhea - providing amoxicillin or some sort of Coartem-based treatment and oral rehydration solution for dehydration. This is an extension of the aforementioned child survival wave of revolution. This model, even though it is the dominant model, can become a sort of platform for how one can move forward.

Barnett\textsuperscript{22} has asked for a few major categories for community health workers in the mental health space. Palazuelos noted that the terms may not be the ideal choice, but they are already published in the mental health literature, so worthwhile to present here. He presented Figure 4 to distinguish between four different “buckets of care” that could be considered while moving forward: outreach/navigator, auxiliary care, stepped-care, and primary providers. The outreach navigators do more screening and referrals, while the auxiliary care workers are promoting treatment and adherence (i.e., the accompaniment function). He noted that in some parts of Latin America, “auxilarianes” are actually providing care, such as injecting penicillin, so this term could be confusing to some. Stepped-care programs are used to

\textsuperscript{21} Walsh and Warren 1979
\textsuperscript{22} Barnett et al 2018
communicate that a CHW is part of a team in the position of supporting what the nurse or doctor has decided to do; it consists of a lay healthcare worker providing the first step—usually prevention-level treatment—followed by referral to a professional, who goes a step further. Depending on the setting, CHWs as primary providers may also provide treatment in communities without professional providers. For example, CHWs in refugee or very remote rural communities may need to provide the bulk of care, but ideally with some sort of supervision function added to support them in this work.

Figure 4. Disparities in mental health services

2.3.1 Care delivery value chain and five spice model

Palazuelos noted that PIH construes each of these tasks as functions across a care delivery value chain (see Figure 5), a concept adapted from the business literature, especially Professor Porter’s work from Harvard Business School. Each task is considered part of a sequential experience as a patient goes through the continuum/care cascade to get a high value outcome (defined as: the best possible outcome for the lowest possible cost). Though not about cost effectiveness per se, he said, it is about new investments, bigger return on investment, and better value.
Years ago, PIH developed a framework called 5-SPICE, an acronym for five essential elements that has since been adapted and can be utilized to build out a program (see Figure 26). It outlines five critical questions to ask when building a health program:

1. Are people being given the **right task or job** to really make a difference?
2. Are they the **right people** to do that job?
3. Do they have the **right training**?
4. Are they receiving **fair pay** that is commensurate with what is being asked of them?
5. Are they getting **enough mentoring and supervision** to do their work with excellence and fidelity to ensure quality performance every time?
2.3.2 Building the investment case for community health workers

Palazuelos said that there have been multiple reports about CHWs from the private sector and nongovernmental organization (NGO) spheres. The reports’ recommendations are very similar to those generated by WHO. “There’s nothing new and this isn’t rocket science,” he said, “but the question is how to get this to everyone everywhere.” He presented an investment case from a group called Financing Alliance for Health, which supports governments in trying to create ambitious and well-funded community health programs. They provide pro-bono ad hoc support to cost out programs, to think through the financing model, and to help navigate the financing cascade. Figure 6 is an example of an analysis of financing options, the mostly likely and highest feasibility financing streams, and long-term sustainability. “Governments are often profoundly debilitated from years of neoliberal reforms,” he added, “and may benefit from accompaniment in navigating the complexities of financing community health programs.” “The key takeaway from the analysis is return on investment,” he said. When productivity of the work force,
insurance against calamity and the future, and employment (especially of women) are factored in. Investing US$1 in CHWs at scale can return up to US$10 in the long term in certain contexts. Palazuelos was hopeful that this would entice Ministers of Finance to consider investing in CHWs. In contrast, he noted, the 1 million community health care worker campaign is considered by many as a failure since it did not succeed in launching a million healthcare workers. Nevertheless, he commended the campaign for their leadership, and for calculating the cost of what 1 million community healthcare workers in sub-Saharan Africa could actually cost: US$3 billion. According to a USAID report, in conjunction with the Financing Alliance for Health, all the money currently being spent in 2018 on community health in sub-Saharan Africa was just US$1 billion.25 Palazuelos warned: “The most barebones, Band-Aid of a system – not more doctors, a care continuum, or even a truncated value chain – suffers a whopping gap of US$2 billion. These things are profoundly underfinanced and are not near reaching goals.”26

Figure 7. Example of investment case for financing a community health program

Source: Palazuelos, Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018.27

Palazuelos turned to what this looks like on the ground (guided by 5-SPICE), using the example of what a sample country wanted to be done—including practical questions from many different groups within the ministry.

2.3.3 Applying the 5-SPICE model

Palazuelos offered a real-world example of how this could be applied on the ground using the 5-SPICE model (based on his experiences working with PIH and the Financing Alliance for Health in Sub-Saharan Africa). He began by outlining what different groups within the ministry wanted to be done in each of the five categories. The right job wish-list included

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25 USAID 2017
26 Palazuelos 2018
going house to house for assessments, going to houses to visit well mothers and children, waiting at home to do ICCM, reporting deaths and cases, and reaching 1:1000 people (approximately 200 houses). The right people were pro-social, educated male farmers that had to meet basic needs with income. The right training was in line with the established model: an initial three sessions plus continuous monthly trainings. The right pay was just USD$20 per month, despite the minimum wage in the country being five times higher, because the country is highly dependent on foreign donations and had only US$15 million with no further commitments for new donations. The aspirations regarding mentoring and supervision were that peer supervisors (selected by the CHWs) would only do supervision work; they would receive a higher salary and travel stipend. Palazuelos asked participants: “What is wrong here? How does each question fit together? Is there a balance in how this program was created? What recommendations should be given to this government?” One participant commented that the pay was unfair and would not provide the incentive to provide quality care. Palazuelos replied by asking whether fairness is an important criterion for successful community care work. Another participant questioned the use of pro-social educated farmers going into women’s homes, to which Palazuelos responded that even if inherited cadres are not necessarily the best people for the job, replacing them with more suitable new workforce of trained recruits would require firing all of the existing workers: “what happens when there are 15,000 previously employed, marginally educated men that now suddenly have been fired? A little bit of revolution.” Palazuelos helped brainstorm several recommendations to be considered in the face of this context. The first was to decrease the number of tasks, which is a challenge when programs are vertical. The second was to increase salaries, despite the lack of money. The third and fourth were to reduce the ratios and increase the number of CHWs. The fifth was to improve the work flow by decreasing the amount of time spent going from house to house.

Palazuelos explained that these recommendations are representative of the types of trade-offs made in real life when these complicated programs are being built. This is important, because major analyses have shown that community health worker programs are too often set up to fail. One study looked at three large countries—Burkina Faso, Ethiopia, and Malawi—and assigned scores for ICCM policy readiness (based on presence of a national ICCM policy and availability of trained staff and drug stocks). Although Ethiopia had a high readiness score (2.3/3), they ultimately found no reduction in under-5 mortality attributable to the ICCM program. The same was found in Burkina Faso and Malawi (with relatively lower readiness scores). He noted that these analyses are years old, and that these countries have done things to go on and improve the situation. He commended Ethiopia in particular as having done a good job identifying the reasons why people were not going to community health workers for care and created a volunteer army to go out and pull people into care. Their thinking was that in order to improve health-seeking behavior, they needed to prod people to go into the clinics. There is a choice to make in plotting the way forward, said Palazuelos: “…should a moral stance be taken, or should everyone be happy? Should feathers be ruffled by saying that it is morally wrong to do certain things?” “Different groups have very different functions,” he added, “highlighting the disparity between WHO and a community health impact coalition, for example.”

2.3.4 Ways forward

Muso is an example of an NGO that has effectively improved the ICCM program and making it work better on a smaller scale, said Palazuelos. Instead of being passive, CHWs actively search for sick children and provide care on the ground within 24 hours. Due to the
sharp increase in active case finding, the Muso catchment area had the fastest reduction in under-five mortality ever reported in human history. Palazuelos attributed this astounding achievement to Muso finding the right job—being proactive instead of passive. The big question going forward, he said, is to find the equivalent for mental health.

Box 4. Practitioner expertise to optimize community-led health systems

Work similar to the five spice model has been done in the arena of practitioner expertise, said Palazuelos The CHW Impact group identified eight factors for optimizing community-led health systems.29

**Accredited**: The health knowledge and competencies of CHWs are assessed prior to practicing; CHWs must meet a minimum standard before carrying out their work.

**Accessible**: To improve accessibility, timeliness, and equity of care, point-of-care user fees should be avoided when possible.

**Proactive**: For active disease surveillance, CHWs go door-to-door looking for sick patients and providing training on how to identify danger signs and quickly contact a CHW.

**Continuously Trained**: CHWs are trained using modular delivery or other types of in-service learning. Continuing medical education is not only available to but required of CHWs.

**Supported by a Dedicated Supervisor**: On a frequent and regular basis, CHWs benefit from a dedicated supervisor who assesses patient experience and provides 1-on-1 coaching.

**Paid**: CHWs are compensated financially at a competitive rate relative to the respective market.

**Part of a Strong Health System**: CHW deployment is accompanied by investments to increase the capacity, accessibility, and quality of the primary care facilities and providers to which CHWs link, including pharmacy management.

**Part of Data Feedback Loops**: CHWs report all data to public-sector monitoring and evaluation systems and data get used by those who collected it to improve programs and CHW performance.

29 Ballard et al 2017
Ethiopia is attempting to achieve such success at the country level, he added. They have made a major attempt to finance the national health program, built health facilities, mapped out the communities, and carry out both active and passive care delivery that is well integrated into the health system with a clear referral chain. They are rolling out mHealth and CHWs receive text messages to attend to certain patients. However, in trying to scale up so many different health service packages, mental health ended up being combined with other interventions; as a result, there are many tasks in the baskets of community health workers; this is a problem that has not yet been solved. Palazuelos concluded with a final thought: “Community health workers are not just tools, they are human beings. They are our colleagues. It is often them against the world and the task ahead of them is huge. Community health workers are only as strong as the systems supporting them. If community health workers fail, it is because we have failed them.”

2.4 REVIEW OF TECHNOLOGY AND PRIMARY CARE INTEGRATION

Andrew Ellner explored how technologies can be integrated with primary care—including mental health care—at the health center level. He is the Director of the Program in Global Primary Care and Social Change, the founding co-director of the Harvard Medical School Center for Primary Care, Assistant Professor of Medicine in the Division of Global Health Equity at Brigham and Women’s Hospital,
and the cofounder and CEO of Firefly Health, a technology-enabled primary care services company. To reach UHC by 2030, said Ellner, the role of technology in integrated primary care must be seen in a profoundly different way. Technology can serve to accelerate progress toward this goal, but it requires understanding what technology is good and bad for, as well as strategies for leveraging its full potential to help.

As a primary health care practitioner, cases faced in the clinic are the typical starting point, so Ellner opened with a case study to contextualize some of the barriers that must be surmounted to achieve UHC. “Ms. W” is a 45-year-old single mother of two, with a history of abusive relationships. She works nights as a housecleaner and smokes and drinks alcohol above recommended limits, as well as occasionally using illicit drugs. Despite having depression, uncontrolled diabetes, and hypertension, she has a low level of engagement with medical treatment. She will often miss appointments due to her work and family commitments; she also has difficulty in treatment adherence. These types of challenges are global, he said; in every country in the world, the last mile is not just about distance but about complexity.

Reaching UHC will require understanding how systems need to be dramatically strengthened. This is not the first global push toward UHC, so it is critical to consider opportunities to learn from past mistakes and do things differently this time to achieve the goal. Important changes over the last half century include the shift in burden of disease, the shift in the socioeconomic development of many countries around the world, and the opportunities to integrate technology with health care.

Ellner emphasized the neglected epidemic of chronic disease and the increasing momentum of the shift in the burden of disease toward those diseases in low-income countries (see Figure 9). As they continue to grow socioeconomically, the lowest income countries face a mounting dual burden of both communicable and noncommunicable diseases. The 2013 Lancet Commission Global Health 2035 put forth the concept that in the lifespan of those currently living, there will continue to be further socioeconomic development and improvements in basic infrastructure in the lowest income countries that will converge with the challenges faced by the global community in terms of both acute and chronic diseases.30
2.4.1 Healthcare challenges and barriers to UHC

Ellner outlined some of the healthcare challenges in emerging economies. An estimated 150 million people around the world face catastrophic healthcare costs each year, around 100 million of whom fall into poverty as a consequence of poor financial risk protection. Around 400 million people worldwide lack access to essential health services. Ebola, chronic diseases, and ensuring safe pregnancies are critical challenges. The dialogue around UHC often has a singular focus on insurance coverage and paying for care, as has been the case in the US. Ellner called for shifting the focus to the services that are actually being delivered, how they are designed, the financial costs, and the opportunity costs. Ellner warned, “...the failure to innovate or change the way that services are delivered, coupled with the increasing burden of noncommunicable disease, has led to out of control health spending around the world.” He reported that according to OECD health data between 1980 and 2013, healthcare spending as percentage of GDP have seen an inexorable rise in spending on healthcare, which starts to crowd out other things that might be more important for
people’s health, such as transportation or housing.  

2.4.1.11 Global health workforce shortage and productivity issues
The challenges associated with the global health workforce shortage of 4.3 million are felt acutely around the world, said Ellner. Inequities increased due to migration of healthcare workers from LMICs to high-income countries and the shortage threatens the quality and sustainability of health systems around the world. The problem lies not only in the absolute numbers of people needed in the workforce, but in failing to ensure that what the existing workforce is doing is efficient, effective, and scalable.

Like workforce shortages, health workforce productivity issues will need to be addressed to accelerate progress toward UHC. Many health facilities have sufficient people, infrastructure, and supplies, but low productivity. The productivity of the workforce needs to be optimized by putting systems in place to generate demand and reinforce the work being done. In LMICs, both public and private health care is of low quality, with evidence showing that practices score low on infrastructure, clinical competence, and practice; accountability measures among providers has also been shown to be weak. The US probably has an oversupply of physicians, said Ellner, yet the labor productivity of the healthcare workforce has not changed in any meaningful way in the last 20 years. This stands in stark contrast to the incredible gains in productivity across the board in other sectors of the economy. He attributed this in part to the fact that technology has not been leveraged to increase productivity and has actually decreased productivity in some cases. An example is the introduction of electronic health records designed to capture revenue for fee-for-service payments rather than being tailored for use by healthcare workers.

2.4.2 Reframing primary care
Attempting to expand health coverage in the face of huge gaps in the healthcare workforce and healthcare financing are problems that are compounded by barriers to health workforce productivity. However, technology in and of itself is just part of the solution. To accelerate toward UHC, said Ellner, technology needs to be situated within a fundamental reframing of primary care delivery. To illustrate, he described the received, decades old view of primary care and its structures. Under this conceptualization, primary care is the first contact by a doctor or nurse at the first level, which is typically thought of as a physical location (e.g., clinic, center, or station). Primary care is considered basic, inferior care; “real” doctors and “real” care need to be accessed at a hospital. This conceptualization is highly problematic, said Ellner, who contrasted it with a completely reframed vision for primary care in 2030.

In 2030, primary care 2030 “…serves as the main entry point into the health care system for the majority of health problems, provides proactive delivery of key preventive services to populations, and manages chronic conditions over time.” It is “continuous…people-focused and comprehensive, addressing the health needs of all members of society across the life course... may include integrating and coordinating secondary and tertiary levels of care.”

Reframing and rebranding primary care will require disseminating the message that primary care is not just basic or inferior care, but the best care for everyone. This story needs to be told in a novel way that is less focused on the structures of primary care, the roles of specific healthcare workers, and care that requires physical interaction. Ellner called for thinking holistically about services being provided and how primary care can improve the functioning of the healthcare system at large. Key functions when discussing primary care are continuity, comprehensiveness, integration, and coordination. The aim, said Ellner, should be to determine what needs

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31 Ellner 2018
32 Source: www.phcperformanceinitiative.org
to be accomplished and find the best way to deploy healthcare workers and technology to accomplish it in a much better and faster way.

Data will be critical to this fundamental shift, observed Ellner. The previous use of paper-based data reported "up" to higher levels and donors, and then used for punishment, requires extra labor or diverts existing labor. It is also focused excessively on quantitative disease or intervention targets, he added. However, deploying technology in new ways provides a host of opportunities to collect data and drive acceleration. In his vision of 2030, one of the opportunities provided by technology is unprecedented access and power in analyzing data and fueling advanced analytics. Data should be collected passively as part of care process, then shared seamlessly and transparently to capture all dimensions of service and system performance. If it is done appropriately in concert with service delivery, the necessary data can be collected without requiring extra people to do the work. Patients can be empowered as one of the main data entry points in a process that should drive continuous improvement and learning at the point of care.

Ellner then reflected on the power imbalance skewed against patients in today’s primary care systems. It is a consequence of the hierarchical approach, a failed strategy in healthcare in which the doctor and hospital have all the power and the patient has little or none. The patient is often construed as a passive recipient of a technically complex service, who is lucky to get any care and should be quiet and follow directions. Judging patients compliant or non-compliant feeds into this dialectic. The health workforce often lack even basic camaraderie, which is antithetical to driving organizational performance and creating health for patients. The real disruptive innovation is not technology, said Ellner, but changing the culture and the approach to the organization and delivery of care. Everyone must be empowered to work as equal members of a team, including patients and families. In contrast, the patient in the 2030 vision is an essential partner in care processes and outcomes, as well as a critical producer and consumer of data and other health information. Those who are constrained by structural barriers or health challenges may require extra support to adhere—from CHWs, for example.

Ellner emphasized that as the burden of disease shifts from acute to chronic, there must be a seismic change in health systems and their ability to respond. The orientation of the health system must shift in its ethos from “react and rescue” to “engage and empower.” The role of the patient should transition from passive to active. Key provider competencies must shift from a focus on training for technical competencies, such as diagnosis, to working within and leading teams within high performing systems and organizations.

### 2.4.3 How technology can enable primary care: key principles

Technology can enable primary care, but there are constraints around what it can and cannot do. Ellner outlined three guiding principles. First, technological innovation in isolation from innovation in health worker team roles, work processes, and relationships – particularly with patients – has little value. Most of the new digital apps for health are toothless and ineffectual due to the misconception that technology alone is the answer, upon which billions of dollars have been wasted. Instead, it must involve a deep redesign of the work that healthcare workers do, integrating technology and thinking about the way that technology powers changes in relationships, behaviors, communication, and coordination. The second principle is that technology can be a force multiplier in terms of care efficiency, quality, and safety in primary care, but only if it is deployed to complement human strengths and capabilities. Much of healthcare is algorithm, he said, which is an area in which technology surpasses the capacity of human providers, providing an opportunity to support them in tasks that can be standardized and allow them to concentrate on complexity.
and relationships. Technology is also good for communication and coordination across groups of people. Technology should also be designed to support data collection in a way that does not create extra work that impedes the process of care delivery. The third principle is to develop an enabling ecosystem for technological innovation in primary care, said Ellner. This will involve developing standards for data, ensuring data interoperability, and establishing the right to privacy and ownership of health data.

2.4.4 Primary care as a platform

Primary care is a platform that must be well-functioning to be scalable toward UHC, said Ellner. The platform encompasses teams of people into which technology is integrated to perform functions of data collection, analytics, and intelligence that strengthen the entire platform. He provided two examples of non-profit organizations that are building open-source software intended for the global public good. Watsi builds technology to do basic insurance functions including member enrolment, member identification, claims submission, claims processing, and reporting. A program piloted in Uganda signed on virtually the entire population of two rural villages, which is soon to be scaled in another country in Africa. The technology was built to address challenges in global health around patient identification, enrolment, and management to make the workforce more productive. Medic Mobile builds software for health workers providing care in the hardest-to-reach communities; the Medic Mobile toolkit is free, open-source, and designed in collaboration with health workers. Ellner noted that it may be particularly relevant to CHWs. The software could empower CHWs in tracking people over time, managing tasks important in the delivery of service, and coordinating tasks across teams of people in different parts of the health system in a reliable way. Different team members can help manage tasks and provide decision support. It helps standardizes some of the basic care that is delivered, then surfaces the data on that care to front-line teams and managers to drive improvement.

Ellner concluded by reiterating that achieving UHC will require disruptive, technology-enabled models of primary care. This will require reframing the basic tenets of care delivery and integrating innovations in technology with innovations in human systems. He cautioned, “...be skeptical of anyone claiming their technology will revolutionize what is being done...the fundamental innovation is the work being done thinking deeply about the role of health workers, their work processes, and then how technology can come in to make it more efficient, effective, safe, and reliable.”
3 Community health worker roles, tasks, and polyvalence

3.1 INTRODUCTION

The third chapter summarizes workshop content in the domain of community health worker (CHW) roles, tasks, and polyvalence. Content includes a review presentation on the topic, highlights from the panel of expertise, as well as report outs from the first and second working group sessions and the subsequent large-group discussions.

The working group was asked to define the specific tasks and roles that CHWs play in care for common mental disorders (CMD). They were asked to explore the range of roles in which CHWs should engage with regard to CMD care and the core competencies needed for CHWs to perform those roles effectively. The group also discussed ways to address the issue of CHW polyvalence—that is, the idea that CHWs should address tasks across medical and social conditions—such that the essential tasks of mental health care delivery for CMDs is addressed in an efficient and effective way. Potential risks and barriers to CHWs providing CMD care were also examined with a view to how those risks and barriers could be addressed. Finally, the group considered the relative advantages or limitations related to generic CHWs providing care for CMDs as opposed to specialist mental-health CHWs.

3.2 COMMUNITY HEALTH WORKER ROLES, TASKS, AND POLYVALENCE: REVIEW PRESENTATION

A review of CHW roles, tasks, and polyvalence was presented by Brandon Kohrt, professor of Global Psychiatry at George Washington University (USA) and technical advisor to the Transcultural Psychosocial Organization (Nepal) and to the Carter Center Mental Health Program (Liberia). He opened by highlighting the pervasive undertreatment of depression across the world (see Figure 31). It is oft-cited that in high-income countries, only 22.4% of people with depression are receiving minimally adequate treatment. However, just 3.7% of those with depression are receiving minimally adequate care in LMICs—and data is not even available to estimate the rates in low-income countries. He characterized this as an ideal starting point for discussing the myriad roles that CHWs can play in addressing mental health needs. Using the same figure, Kohrt emphasized the importance of the data on the percentage of those with depression who perceive the need for treatment, which is predicated on the acknowledgement and recognition of depression as a treatable condition. Not only is access to care for depression very poor, he explained, there is widespread lack of awareness across the world that depression can be treated. This further bolsters the potential extent to which CHWs can help to engage people with treatment services, beyond simply providing care.
3.2.1 Evidence base for the role of community health workers in mental health

In his research, Kohrt focuses on the critical challenge of establishing an evidence base. Although there is a large swath of CHW applications focused on mental health, the actual benefit of those is often unknown. “if we don’t know the effectiveness of those services,” he explained, “it is exceedingly hard to judge how to best use funding.”

3.2.1.2 Existing community health worker interventions for common mental disorders

Kohrt surveyed existing CHW interventions for CMDs. For example, the Programme for Improving Mental Health Care (PRIME) is a consortium of research institutions and Ministries of Health in India, Nepal, Ethiopia, South Africa, and Uganda. Its goal is to generate research evidence on the implementation and scale up of treatment programs for priority mental disorders in primary and maternal health care in low-resource settings. PRIME involves CHWs in many of their mental health care implementation plans. Another example is the Thinking Healthy program, a low-intensity psychological intervention; its manual outlines an evidence-based approach for CHWs to help reduce prenatal depression through evidence-based cognitive behavioral techniques recommended by mhGAP.

Mental Health Beyond Facilities (mhBeF) was an evidence-based comprehensive
community-based mental health services package aligned with the Mental Health Gap Action Program (mhGAP) in post-conflict countries including Uganda and Liberia.\textsuperscript{40} The Friendship Bench project\textsuperscript{41} is an evidence-based intervention developed in Zimbabwe to improve access to treatment for CMD through problem-solving therapy delivered by lay health workers. The project is now adapted in New York City.

3.2.1.13 Literature review: the role of community health workers in effective programs

A recently published review by Kohrt and colleagues\textsuperscript{42} examined the evidence base around the role of CHWs in effective programs for community-based delivery of care, as a landscaping start to exploring the range of roles they can play. The review of reviews identified 23 publications that summarize the literature to date. The authors analyzed trials with demonstrated effectiveness to better understand the conditions under which CHWs were engaged and there was a known positive outcome. Kohrt noted that although they could not determine specifically whether the CHW element contributed (or not) to the positive outcome, the CHWs were part of an effective trial in each of those cases. They summarized the roles of CHWs in those effective trials into six domains:

1. Why CHWs were involved (i.e., the justification for including them)
2. Where CHWs carried out activities (not only physical space, but also any use of technology)
3. What the CHWs were doing (i.e., the scope of roles they assumed)
4. Who the CHWs were (e.g., lay people, peers, primary care workers, formal government-sponsored role, etc.)
5. How the CHW processes were put into place
6. The potential harms and risks when using CHW (both to the beneficiaries of care or the CHWs themselves)
3.2.1.13.1 Why involve community health workers?

**Why involve CHWs?**
- Other platforms are unavailable or unacceptable
- Enhanced quality through community platforms
- Family member involvement
- Economic productivity
- Social inclusion

In many contexts, other platforms are not available. This could be the consequence of disaster, war, or any situation in which there are no primary care facilities. In settings with political conflict, a certain political group may control the health facilities, persecuting members of other groups who are seeking care without being persecuted. During the Maoist insurrection in Nepal, for example, primary care workers were pressured to report on individuals they suspected of being Maoist. In settings where other platforms are available, mental health care delivered by CHWs may be the most acceptable option. For example, studies in Pakistan and other parts of South Asia have shown that cultural expectations around gender may make it unacceptable for a woman to seek mental health care individually, but in-home delivery of mental health care was a more acceptable process.

In settings with existing primary-care-based mental health services, it may still be beneficial to include community-based mental health services. CHWs can extend the reach and quality of that care. Understanding how and where people live helps to tailor interventions. Involvement of family members is an added benefit of involving CHWs in mental health care. Providing care in the community and/or in the home offers greater opportunities to involve a patient’s family in the therapeutic process; community engagement extends the platform beyond health alone. A number of trials carried out in China and elsewhere include the acknowledgement that family plays a key role. Ideally, the community setting also provides a foothold for increasing economic productivity and promoting social inclusion. Kohrt noted that this touches on a question raised by Tarun Dua in her presentation: to what degree are we respecting human-rights-promoting equity in the process of healthcare delivery?

3.2.1.13.2 Where do community health workers operate?

**Where do CHWs work?**
- Homes
- Schools
- Refugee camps
- Community centers
- Technological platforms

Kohrt then turned to where the community health work takes place, which is often in the home; the vast majority of interventions for women during the postpartum period are done in their homes, often through a combination of personal visits and phone calls. In LMICs, school is the setting for the majority of children and adolescents with CMDs who have any access to mental health and psychosocial programs. The range of other potential settings for the delivery of mental health services includes refugee camps—where the need to address trauma-related post-traumatic stress disorder is acknowledged—as well as community centers.

Increasingly, care is being delivered through technological platforms. There were eight effective community-based CMD interventions in their review that were not perinatal. That is, they included men and women outside the reproductive period, half of which were using a technological platform in some way. Many programs that have integrated technology have already shown benefits of doing so, said Kohrt.

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43 Kohrt et al 2018
3.2.1.13.3 What are community health workers’ activities?

What are CHWs’ activities?
- Public mental health literacy and attitudes
- Mental health promotion and prevention
- Case finding and referral
- Case management
- Skills training and psychosocial rehabilitation
- Psychoeducation
- Psychological treatments

Kohrt outlined some of the many roles that CHWs can play across the range of potential settings. He built upon the comments from Dan Palazuelos: figure out the right role for the right individual serving the appropriate need. Starting out broadly, Kohrt noted that CHWs already know and have existing relationships with people in these settings, so they are ideally positioned to help raise general public mental health awareness and literacy, as well as trying to change attitudes toward making it more acceptable to seek care and be treated for mental health conditions (that is, improving demand generation). First and foremost, CHWs already play a large role in community sensitization and this needs to be refined and mined for lessons learned in those experiences.

In addition to fostering general awareness, there are mental health prevention and promotion components to CHWs’ activities that can take place in schools or other community settings. Kohrt noted that this builds upon Vikram Patel’s paper on the spectrum of care for depression and CMDs.44

CHWs are already carrying out health promotion activities related to children’s health and infectious disease, so the question is how to integrate promotion and prevention activities beyond treatment. Kohrt and colleagues’ review found that this was most common in humanitarian settings in the context of preventing PTSD after a traumatic event. Case finding and referral activities include screening for persons with idioms of distress and facilitated case finding (further detail provided in the Nepal case study).

The next role is the case management or navigator role—once a patient is already in care, how can a CHW ensure that they get the needed follow-up, home-based services, and PHC-based services to support treatment adherence, as well as make sure the patient’s family is getting any additional care they may need. Kohrt and colleagues’ review found that this case management role was extremely rare for CMD; almost all evidence-based case management CHW roles are in the area of severe mental illness.45 More work is needed on how case management can also support prevention, treatment and recovery in the area of CMDs. Similarly, skills training and psychosocial rehabilitation in global mental health is almost exclusively done in cases of psychosis and severe mental illnesses. For models of care for CMDs, there is a gap as to how to integrate the skill training, economic support, and psychosocial rehabilitation. Psychoeducation is part of many of these programs, typically as a component or isolated intervention in humanitarian settings. In some cases, the review identified purely psychoeducational interventions that include CMDs, and are often focused on PTSD. CHWs can also play a role in psychological treatments and have shown effective outcomes in different types of roles. These psychological treatments include low-intensity interventions such as cognitive behavioral therapy, interpersonal therapy, trauma-focused therapy, motivational enhancement, or the common element treatment approach.

44 Patel 2017
45 Kohrt et al 2018
Who are community health workers?

Who are CHWs?
- Community health workers
- Other health professionals
- Formal providers outside the health system
- Non-formal providers

Kohrt underscored the importance of being aware that when people speak about CHWs, they are not always talking about the same cadre in the same contexts. This highlights the need for clarity about expectations regarding roles and responsibilities. It is also important to distinguish which kinds of evidence are generated by different types of CHWs. In many settings, the government has an established cadre of CHWs who are often unpaid or paid through trainings and occasional per diems. In other settings, health professionals can play the community-based role while situated in a different part of the health system. These include primary care providers, nurses, and midwives. Formal providers outside the health system may also be involved in the role, such as teachers. Police are playing an increasingly important role in many settings because law enforcement—rather than health workers—serves as the first line of care. In Liberia, for example, the police have been trained to provide identification and referral services.46

46 Kohrt et al 2015a
3.2.13.5 How are community health workers’ processes implemented?

### How are CHW processes implemented?

- Service-user involvement
- Integration into other activities and platforms
- CHW selection and recruitment

Kohrt then turned to how the CHW processes are implemented. He noted that WHO’s Strategic Plan, the Disease Control Priorities and the World Psychiatric Association recommendations for community mental health all highlight the need for **service-user involvement**. Kohrt and colleagues’ review found that this was rarely done in existing initiatives and there is a need for better evidence-based strategies for doing so.

CHW processes need to be **integrated into a range of activities and platforms** beyond health, including educational platforms as well as in areas of economic productivity and human rights initiatives.

**CHW selection and recruitment** are critical in helping to inform training and supervision practices. In the current landscape, when selection and recruitment are more exclusive and selective, the amount of training and supervision needed is lower. However, in a setting in which large numbers of government CHWs—engaged via a broader come-one-come-all selection and recruitment program—**training and supervision** models warrant much more attention. In terms of **incentives and certification**, CHWs in many settings are not compensated very highly. **Use of technology** in implementing these processes was the final component highlighted in their review.

3.2.13.6 Models of primary care integration

Borrowing from work done by Nadja van Ginneken, Kohrt provided an overview of different models of primary care integration (see Table 31). He described how CHWs can play different roles in different contexts and maps out different approaches to integrating with primary care and specialists. He noted that in LMICs, it is common for specialists to interact directly with CHWs—in effect bypassing the primary care level entirely. Kohrt referred participants to work done by PRIME in Nepal in implementing district mental health care plans. In the model detailed in, CHWs are involved in sensitization and community informant detection. He suggested that this has good potential to be expanded in other settings.
Table 2. Models of primary care integration

<table>
<thead>
<tr>
<th>Model</th>
<th>Primary care roles</th>
<th>Community roles (lay health workers)</th>
<th>Specialist roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>Independently manage</td>
<td>Community sensitization</td>
<td>Training only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identification/referral</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychosocial and non-specific counseling interventions</td>
<td></td>
</tr>
<tr>
<td>Consult-liaison</td>
<td>Independently manage</td>
<td>None identified</td>
<td>Ongoing education</td>
</tr>
<tr>
<td>Collaborative care</td>
<td>Manage while linked to specialists through care manager</td>
<td>Lay health workers assume primary care roles (trained by and work with specialists)</td>
<td>Shared care decisions</td>
</tr>
<tr>
<td>Community outreach</td>
<td>Exclude organic disorders</td>
<td>Identification/referral</td>
<td>Outreach clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychosocial support and counseling</td>
<td>Home visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health first aid</td>
<td>Care coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vocational training</td>
<td>Advocacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Administration</td>
<td>Lead organizations</td>
</tr>
<tr>
<td>Identification, awareness, and referral</td>
<td>Identify and refer to specialist</td>
<td>Identification, referral, and follow up Sensitization</td>
<td>Training only</td>
</tr>
</tbody>
</table>

Source: Kohrt, Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018. 50

50 Data sources: Bower 2011; van Ginneken et al 2017
1.1.1.1.1 Proactive case finding
Kohrt connected the concept of community informant detection to the concept of proactive case finding. Rather than doing universal screening—which is often inefficient and produces inaccurate results—it is important to find a way to help CHWs identify people in need in the course of their daily work. Jordans, Luitel, Subba, Kohrt and colleagues at Transcultural Psychosocial Organization Nepal have developed a prototype-based approach to proactive case finding that incorporates images and vignettes. The approach involves three prongs: detecting of persons with mental illness in the community; assisting a person with initiation of care at a primary healthcare facility; and monitoring in the community to make sure the person is adhering to treatment. The approach helps CHW identify people they see at home and in their communities, then to engage those people by connecting their stories using their training (for example: “your story sounds a lot like people who might like to get treatment in some way. Would you like to get treatment?”). This helps both to identify cases, refer to treatment, and encourage linkages with care. The person identified now has a specific CHW who is able to help follow up with treatment, adherence, and care through a home-based treatment model.

1.1.1.1.2 Context for community mental health participation in CMD care
Kohrt explored the context for community mental health participation in CMD care. He emphasized the importance of thinking not only about CHWs, but about the interaction between CHWs and their specific context, which determines their roles. He used Figure 33 to explain how the level of CHW involvement and support are often contingent upon the level of specialist services available: in settings with high levels of available specialist services, there tend to be lower levels of CHW involvement, and vice versa. That said, the majority of the

51 Jordans et al 2015; Jordans et al 2017a; Subba et al 2017
The world’s population does not have access to either mental health specialists or CHW mental health care. In high-income countries, although there are a number of models with specialists available, there are often links with community health care. In his work, Kohrt has seen an emerging effort to increase the role that CHWs play. In some instances, this is in the absence of integrated specialist partnership or cooperation, and the CHW are more autonomous, independent and responsible for management without appropriate support. This raises questions about feasibility and the degree to which CHWs should be expected to have narrow scopes work (e.g., just HIV, child development, or diabetes) versus a broad population-wide approach.

Figure 12. Context for community mental health participation in common mental disorder care

Notes: MH = mental health; HIC = high-income country; LMIC = low- and middle-income country; THP/P = Thinking Healthy Program - Peer Delivered; UK IAPT = Improving Access to Psychological Therapies; PM+ = Project Management Plus; HAP = Healthy Activity Program; CETA = Common Elements Treatment Approach
Source: Kohrt, Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018.

1.1.1.1.3 Community health worker competencies
Kohrt highlighted the critical and persistent issue of CHW competencies. His research has identified six key domains of competencies: collaboration; education; promotion; recognition; treatment; and support (Figure 34). He noted that this range of competencies is a huge amount to ask from individuals who may have only a high-school-level education or less. The related issue of evaluating competencies is also a concern, he added. Ongoing efforts include the Enhancing Assessment of Common Therapeutic Factors (ENACT) tool for evaluating competencies; and WHO’s Ensuring Quality in Psychological Support (EQUIP) project, which is working to identify and develop tools to evaluate helper competencies (see Figure 13).
3.2.1.13.7 Harms and risks

Kohrt turned to the impact and potential harms and risks posed to CHWs themselves, highlighting some of the issues that have recurred in his research. CHWs may often receive **limited (if any) compensation** for delivering services, while receiving **per diems to attend trainings**. For CHWs, this can serve as a disincentive to provide care and an incentive to attend more trainings instead. There may be a perception that mental health care **disrupts the delivery of other health services** that may be required to be reported and recorded, and CHWs do not want those numbers to decrease. CHWs may also feel that trainings might not allow them to achieve
sufficient competence to feel effective: they may choose not to engage in the behaviors if feel they have lack of competency to help. Stigma is another crucial area to be addressed, as well as the fear of violence or contagion. Kohrt said that ideas of severe mental illnesses are often mixed with substance abuse and CMDs. Health system preparedness is another critical concern: systems may be unable to integrate the new skills that CHWs have acquired, due to lack of medications, services, and/or support. Kohrt emphasized that we must not ignore the personal mental health needs of the CHWs who are expected to deliver these services.

3.2.2 Gaps and ways forward

Kohrt concluded his presentation by outlining a set of gaps that need to be addressed in order to move forward (see Box 31).

Box 5. Gaps to address in community health worker roles

Kohrt highlighted five gaps that will need to be addressed to move forward in addressing community health worker roles, tasks, and polyvalence:

- Address contextualization needs alongside competencies.
- Examine livelihood, burden, and mental health needs of CHWs.
- Address the poor evidence base for men’s mental health and integrate men’s CMDs with substance abuse CHW programs for men.
- Frame depression as a continuum and availability of promotion/prevention for adults within stepped-care models.
- Distinguish among emotion dysregulation, social determinants, trauma, and other etiologies (per Patel’s continuum of depression).

Source: Korht, Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018.

3.2.3 Panel: implementers’ reflections on community health worker roles, tasks, and polyvalence

The panel discussion featured participants with on-the-ground expertise involving CHW in CMD care. Moderator Brandon Kohrt asked the panelists to reflect upon experiences where adding CMD care can either increase or impede the feasibility, acceptability, and benefit of other CHW activities. They were also asked to consider how CMD care roles are determined for CHWs and to identify areas in which technology can facilitate CHW involvement in CMD care.
Panelists included:

- Jimena Maza, Partners In Health/Compañeros en Salud, Chiapas, Mexico
- Abhijit Nadkarni, London School of Hygiene and Tropical Medicine/Sangath, India
- Siham Sikander, Human Development Research Foundation, Pakistan
- Lassana M. Jabateh, Partners In Health, Liberia
- Aneeta Pasha, Interactive Research & Development, Pakistan
- Melino Ndayizigiye, Partners In Health/Bo-Mphato Litsebeletsong tsa Bophelo, Lesotho
- Nishat Rahman, Building Resources Across Communities (BRAC) International, Bangladesh

Jimena Maza is the clinical supervisor and primary care director at Compañeros en Salud in Chiapas, Mexico, which is part of the Partners In Health network. Their program was started in 2011 staffed with CHWs and early career physicians, but no psychologists or social workers. They integrated PHQ 9 screening at the outset and eventually validated the PHQ 9 screening. In subsequent years, Compañeros en Salud has carried out multiple qualitative studies linking depression to social determinants and developed a data collection system for depression care. They have also established groups for people with depression and those wrestling with overtreatment of antidepressants.

Maza reflected one of the many responsibilities that CHWs have—how to treat mental health patients in a more holistic way after they have been found. In Mexico, many people have been diagnosed and started on treatment, but they often reach a point they cannot go beyond. She noted that in the context of treatment, physicians tend to first think about giving patients medication. But mental health patients need more than just pills, she said: “...they need to talk, to be heard, to become normalized, and to acquire the tools to fight their own battles.” She conceded that physicians have a tremendous workload that does not allow time to provide active healing for all of their patients, but she suggested that this can be done very efficiently by CHWs. In her setting, they are considering giving these responsibilities (with supervision) to community health professionals (CHPs). To prepare, CHPs have been incorporating competencies skills in therapy (including the ENACT scale), active hearing, empathy, and so forth into their competencies. At the outset of the program, the CHWs were focused on a range of different diseases (e.g., epilepsy and diabetes). However, because patients with MH issues need more time than other types of patients, in 2018 they began training CHWs who are specialized in mental health. In terms of technology, they have started working with Concur, which was quickly grasped by the CHWs. This bodes well for the roll-out of more technological platforms in the future, she added.

An addiction psychiatrist and global mental health researcher, Abhijit Nadkarni is the Director of the Addictions Research Group at Sangath, a research NGO based in Goa, India. He has been a collaborating scientist on many projects, from alcohol use and domestic violence to developing and evaluating technological interventions for tobacco and alcohol use. Nadkarni applied the five spice model to reflect on how his group’s research work translates to practical application.

In terms of the “right job”, Nadkarni remarked that research-controlled trials in Goa, India, started with one CHW (or lay health worker) delivering one intervention for one disorder, but this does not work in real-world practice. He explained that as part of the National Rural Health Mission, the government of India’s Ministry of Health and Family Welfare established a cadre of accredited social health activists (ASHA) in 2005. He described ASHAs as general CHWs who do everything at the coal face. They wanted to develop a program for ASHAs to deliver mental health care as part
of their work and carried out a trial in which CHWs delivered care for both depression and alcohol use disorders. “But that still isn’t good enough for the real world,” said Nadkarni, “because those are just two disorders of many,” Nadkarni continued that it is difficult to find the right person with the right kinds of existing competencies. This is the case even in a controlled world of RCTs, he said. During recruitment for one trial, they were looking for a particular type of people to serve as lay health workers for addressing alcohol use disorder: e.g., middle-aged, educated men with some life experience (because alcohol use disorder affects mainly men in India). However, most of the people they found during recruitment were young women in their 20s. They could not even control for the preferred conceptualization of worker in recruiting for a trial, so controlling for this in a real-world situation is even more infeasible.

In terms of fair pay, Nadkarni reported that in their trials, they gave people more than the minimum wage, because they wanted them to complete the trial and interventions. In some other work in Rajasthan, they had extensive debate about how much to pay health workers during an implementation phase. They wanted to give a certain amount to CHWs, but people argued that because it was too high, others in the same setting would become jealous and would not allow the CHWs to enter their homes. This illustrates how the translation of five spice into different contexts can be very difficult, he added. With respect to training and supervision, Nadkarni observed that CHWs receive weeks of training and weekly supervision when they take part in RCTs, but that does not always translate to the real world—where a single day of training and only monthly supervision by peers or specialists may be all that resource constraints will allow. Leveraging technology to improve supervision (using Skype, for example) seems promising, but the rural areas where they work may not have internet capabilities. “We should aspire to higher ideals,” said Nadkarni, “but when translating research and evidence into implementation, we can’t let the best be the enemy of the good.”

Siham Sikander has worked on maternal psychosocial wellbeing and child development in Pakistan for more than a decade. He focuses on task-shifting interventions through CHWs using the implementation of cluster-randomized trial designs to develop and test interventions for mothers and children. Through his close work with the health system of Pakistan, he has developed close linkages with nongovernmental organizations, the Ministry of Health, and academic institutions addressing health issues in Pakistan. For many years, Sikander has worked closely with the government’s CHW program (the “Lady Health Worker” program) that employs 135,000 lady health workers, making it one of the largest in the world. Each worker visits up to 200 households in a month, largely providing promotive and preventive care. This was initially thought to be the best option for providing community health services, but twenty years on, the program has become overburdened and overstretched, and is staffed by an aging cadre of workers.

Sikander said that they have recently completed trials in Pakistan and India using lay workers—for example, having mothers support the mental health of pregnant women in their own communities. The trials have yielded positive results, he reported. The model was demonstrated to be feasible in both settings, with workers trained to competency through a cascaded model of training and supervision. Going forward, a key question is how to keep the momentum going in case detection. Although promising research has been carried out, it has yet to be tested in on-the-ground settings. Even though the model is feasible, it is unclear how it can effectively be scaled up. “We’ve learned that these lay workers can collaborate very closely with existing health systems,” he said. “Can they be the conduit of a collaborative care model where they could link up with more chronic, redolent, repetitive episodes seen in those areas of Pakistan?” He highlighted two potential opportunities stemming from
his close work with the Ministry of Health in a health and population think tank. Given that Pakistan is interested in working toward universal health coverage and developing a family-practice model of care, it will be important to find ways to incorporate these learnings and leveraging this opportunity of governmental interest.

**Lassana M. Jabateh**, director of community health programs at PIH Liberia, has ten years of experience in developing an in-depth understanding of humanitarian work and field experience in managing and implementing health programs in crisis mitigation, recovery, transitional and post-conflict, and other situations. He has been responsible for oversight of PIH CHW programs, collaborating with the Ministry of Health and partner organizations to manage CHW teams. His work as the key person interacting with Liberia’s Minister of Health has raised questions about how to integrate mental health care. Liberia has established community health programs and the government is now focusing in on closing the gap in areas that are more than five kilometers from the nearest health facility. These underserved “last mile” communities represent 21% of the Liberian population of four million people. They are developing a model in collaboration with the Ministry of Health to serve those last mile communities, with a focus on community engagement, maternal child health, communicable and noncommunicable diseases including tuberculosis, HIV, leprosy, mental health and first aid. Since 2015 PIH has worked with local County Health Team to established community health services within 5km in two counties (Maryland and Grand Gedeh) in the South East. These CHWs are linked to a facility and patients with communicable diseases are assigned to them by clinicians. The CHWs go to patients’ homes and focus on improving patients’ adherence to treatment. He noted that many patients are in denial and do not accept their conditions; thus, it takes time for a CHW to convince the patient that the best solution is to take the medication for the necessary period of time. This has underscored the need for CHWs to receive more training in mental health care.

The people of Liberia has suffered greatly from the Ebola virus disease epidemic and its civil war, therefore post-traumatic stress, depression, anxiety are pervasive problems. Jabateh noted that since CHWs are already carrying out home visits with an assigned set of patients, it would make sense to train CHWs with the skills to identify simple mental health issues, like depression and anxiety, and to refer those people to facilities. However, integrating the community health workforce requires ensuring that they can deliver directly observed treatment to severely ill patients. This is challenging in Liberia, because the community health workforce has relatively lower levels of competency and education that makes it difficult for them to engage deeply in mental health. Furthermore, persuading patients to go to a facility requires the CHW to convince the patient that this service is actually available at the facility—but the availability of clinicians, medications, and services is not always guaranteed. “We want to build a relationship between the community and the facility,” remarked Jabateh. “Remember that Ebola broke the relationship between people and facility. During Ebola, people had no choice in the facility. The common belief was if you went to a facility, you were likely to get Ebola and die.” Since the Ebola epidemic, they have been working to rebuild that relationship between community and facilities by making sure that facilities are appropriately equipped (as the CHWs have told them to expect) and convincing the people that facilities are equipped and designed to serve them. They would like to start using mHealth to reduce the paperwork required of CHWs and allow them more time to spend with patients, but the concern is that mHealth would have the counterproductive effect of replacing in-person training and supervision to CHWs.

**Aneeta Pasha**, director of the mental health program at Interactive Research and Development (IRD, Pakistan), has experience in Pakistan’s development sector working in
sexual and reproductive health and mental health. She is overseeing the expansion of IRD’s mental health program into a large network of primary care clinics in Pakistan using a community-based model and integrating depression care. IRD’s mental health programs largely work at the facility and community levels using CHWs. She shared two major learnings gleaned over the previous few years, which speak to the question of the feasibility of adding tasks to CHW roles. At the community level, CHWs were initially given basic counseling training to go out into the community to screen and treat depression and anxiety. As they were doing this work in the community, much discussion in their sessions related to social determinants of mental health and CHWs would ask what to do about this. As a result, they have evolved the CHW role to become a sort of caseworker for families, helping them to deal with CMDs as well as their social determinants. They have developed linkages to other programs in the community that deal with vocational training, education, microfinancing, adult literacy and so forth. Overall, she reported that the expansion of the counselors’ role beyond mental health to the overall health and productivity of families has been a very positive experience. She remarked that when they tried to integrate mental health into existing CHW programs in diabetes, tuberculosis, HIV, and hepatitis at the facility level, the CHWs were concerned about the increase in their workload. However, when they set up the integrated practice unit for TB, diabetes, and mental health, their experiences were different—the counselors had a sense of pride and it was much easier to implement. “Integration that way was much easier than going to existing staff and saying ‘now you have to take on the mental health care role,’” she added.

Melino Ndayizigiye is working for Partners In Health in Lesotho as a Clinical Director. He has been working for PIH for almost 4 years. He is managing three main clinical programs including a Rural Health Initiative where PIH supports the Ministry of Health in implementing comprehensive Primary Health Care in rural hard to reach areas of Lesotho, a Multi Drug Resistant Tuberculosis (MDR TB) Program where PIH treats patients with MDR TB from all over the country and a National Health Reform program where PIH supports the ministry of health to improve its health system. He is also leading innovative projects including the integration of an Early Childhood Development project into an existing community-based primary health care platform in one of seven supported rural hard to reach sites. Another project includes Providing Universal Health Services for HIV patients, where PIH is building capacity on TB management through didactic training and mentorship to health care workers in three districts and integration of mental health in the existing health services. Since 2017, PIH Lesotho as started capacity building on mental health for its own and Ministry of Health clinical staff. Two rounds of training on mental health have been conducted and mental health services are integrated in the MDR TB services as well as in primary health care services in the rural sites. PIH Lesotho has built a strong relationship with the ministry of health and has started providing technical support to the ministry of health in the area of capacity building and mentorship on mental health.

Ndayizgye explained that Lesotho has a very high burden of HIV (25% prevalence) coupled with very high rates of TB (second highest incidence in the world) and MDR TB. They did a good job putting people on treatment, but they have high targets for outcomes (e.g., for everyone to be virally suppressed) that could not be achieved while they are lagging behind in mental health. CHWs are responsible for many tasks, such as accompaniment, and there is much work to be done in addressing the stigma related to HIV and TB. He suggested that if CHWs are appropriately trained, they have the potential to do an effective job of raising awareness for mental health and ensuring treatment adherence. However, asking CHWs to address mental health in addition to HIV/TB would
substantially increase the burden upon them. Ndayizgye called for thinking about ways to have CHWs carry out basic tasks at the community level, without overwhelming them or imposing an excessive burden. This could involve, for example, raising awareness about mental health, addressing stigma at the community level, and ensuring that patients with comorbid mental health issues, HIV, and TB receive care and accompaniment to facilities for check-ups and treatment if need be. He also suggested involving traditional healers at community level to help refer people to facilities. He said they have not involved technology yet, but they have started using mobile money applications to pay Village Health Workers, which has been going well and has promising potential for health service delivery.

Nishat Rahman is the academic head of the Master’s in Early Childhood Development and the Center for Psychosocial Wellbeing at the BRAC Institute of Educational Development (BRAC University, Bangladesh). Since 2017, she has also been the lead for mental health and psychosocial support for a humanitarian crisis management project at Cox’s Bazaar for the Rohingya population. Her interests include the impact of play in early years, intervention design and effect on children’s developmental aspects, mental health support for mothers, and socio-emotional and development outcomes for children and adolescents.

Rahman said that BRAC believes in scaling up through paraprofessionals; they started working in mental health in 2012, providing training to government care workers, family planning workers, midwives, school teachers, BRAC health workers who provide antenatal and postnatal care, and the Thinking Healthy Program. After training when implementation began, providers reported that the training was exceptional and changed their approach to dealing with clients, but it also changed their personal lives and their dealings with their own family members. As to the question of whether this overburdened the CHWs, Rahman noted that BRAC has a policy of piloting before scale up. They first piloted mental health care by trained paraprofessionals in the Thinking Healthy program, which went smoothly. However, in another intervention they added on antenatal and postnatal care, which was target-oriented work that prevented CHWs from spending as much time in each house as they could in the Thinking Healthy pilot. This created issues and the intervention did not have as great of an impact, she said. They found that too many activities are difficult for CHWs to manage and the intervention was less effective when Thinking Healthy was combined with other activities.

Rahman noted that BRAC has conducted several studies on the para-professional model for mental health, including two randomized controlled trials on community-based psychosocial intervention for pregnant women and adolescents. In one trial, they adapted the Thinking Healthy Program in Bangladesh to address mild to moderate depression, which was delivered by CHWs. The second trial was a school-based psychosocial intervention program for adolescents, which was delivered by teachers. After the studies were conducted, BRAC scaled up this para-professional model in mainstream communities as well as in the Rohingya community in Bangladesh. They have trained CHWs, front-line workers, government health workers, early child development and play facilitators, adolescent club facilitators, and school teachers as para-professionals.

Rahman outlined a set of lessons from her work with BRAC. The first is always to pilot before scaling up. When considering an intervention, go directly to the community and involve them in planning as well as in finding people who are eligible to become trained to help with the intervention. Technology can be used for referral and supervision. In fragile settings, they use a four-tier model: people find clients and refer them to experienced para-professional, who are supervised by
trained psychologists; at the top tier are psychiatrists and clinical psychologists working together. Rahman concluded with a story that illustrates the importance of context, setting, and client’s personal experiences. A 34-year-old client was referred to her with auditory hallucinations and suicidal thoughts. She had seen her child and husband cut into pieces in front of her, she was gang raped and then set on fire, but she survived. Her brothers brought her to a hospital in Bangladesh, but she continued to have problems after treatment. She was referred to the BRAC program and psychiatrists over the phone (technology was used in each tier). “Whenever someone hears a story like this,” she asked, “do you need five clients, or one client per day?”

3.3 WORKING GROUP ON COMMUNITY HEALTH WORKER ROLES, TASKS, AND POLYVALENCE: FIRST SESSION

A presentation of the working group’s discussion on CHW roles, tasks, and polyvalence was provided by Brandon Kohrt and Garmai Cyrus, mental health coordinator for Partners In Health (Liberia). The group worked to create a framework that includes a landscaping activity, identifying the value chain that needs to be addressed, outlining the activities that would be addressed based on the systems in place, and a range of tools and resources for support in implementation (see Figure 15).
3.3.1 Landscaping activity

Cyrus and Kohrt described the seven steps of the landscaping activity, each of which provides critical context in the planning and design phase for CHWs roles and tasks in delivering CMD care. Kohrt noted that the steps are not necessarily sequential and many of the steps must be carried out in parallel.

First is the scope of the problem or the burden of disease as it relates to CMDs versus severe mental illnesses (SMI). The initial step is to map the scope and burden
with existing data, finding ways to obtain or interpolate it in some way.

The second is the key piece of conceptualizations, cultural models, ideas, values, and attitudes toward CMDs in the setting. If a condition is stigmatized, then case finding and awareness raising must have inbuilt, evidence-based approaches to fighting that stigma. Conversely, if a condition is underrecognized, not stigmatized, and is not even a salient social category, then promoting an anti-stigma program is not helpful or is even counterproductive.

Third is community landscaping, which is important in finding the best entry point in the health system or alternatively schools, religious centers, or other sectors of the community in which CMDs exist. Identifying the formal and informal existing supports that are in place is important from the prevention and promotion standpoint.

Fourth is the CHW landscaping activity to understand who the CHWs are, what their goals are, the training they have, and their tasks and availability to take on the workload. Training and certification also fall under this category, as do any existing regulations that apply. Considerations about the compensation mechanism to be put in place are critical, because if existing CHWs already working within the system are given additional responsibilities, they must be paid accordingly (per WHO recommendations).

Fifth is the broader funding landscape to determine who loses and who wins in making funding decisions. This requires identifying existing commissions or policies in place that could be harmonized and advocacy groups that could be engaged, for example.

The seventh is planning to implement, which spans workload and targets per task, logistics, expertise, costs, political considerations, response plans, and the existing cadres and potential new cadres of workers.

During the discussion, Stephanie Smith suggested adding more “how-to” detail about how to carry out the landscaping activity. Kohrt agreed that it would be largely helpful to provide those resources. For example, the first step might include instructions to look at regional statistics, local resources, and the prevalence of risk factors if your CMDs are not in the community. The second step might have some ethnographic-qualitative linkages to other resources and existing tools, such as ethnographic rapid assessment and health system mapping.

3.3.2 Value chain, activities, and competencies

Cyrus continued by describing six objectives in the value chain identified by the working group: health promotion and prevention, case finding, enrolment and engagement, treatment, follow up, reintegration, and linkage. She highlighted some of the CHW activities and competencies linked to each objective. For the health promotion and prevention objective, activities include stress reduction and self-defense for women. Case-finding activities include awareness raising, health talks, fighting stigma, recognizing idioms of distress, and recognition of signs and symptoms. Enrolment and engagement activities include CHWs accompanying patients to facilities for clinic visits, referrals, and case management. Treatment activities range from family psychoeducation to Problem Management Plus (PM+) psychological treatment. Follow-up activities might involve CHWs monitoring for signs and
symptoms, monitoring side effects of drugs, tracking defaulters, family psychoeducation, counseling, and addressing barriers. For reintegration and linkage to other services, for example, a patient might be referred by a CHW who has detected symptoms of mental illness.

### 3.3.3 Evidence, tools, and resources

Brandon Kohrt continued by explaining the group’s idea of “stepping in” using the seven steps of the design phase to identify all the formative pieces that need to be elucidated to make decisions. Simply having the roles and responsibilities is irrelevant if the context has not yet been clarified, he added, which is how exploring those seven characteristics contributes to the process. Those findings are then mapped onto the value chain. He noted that the activities listed are drawn from existing implementation models being used by various organizations on the ground. The group began thinking about evidence for each objective on the value chain, gathered from existing literature reviews and trials. Case studies can be used in areas that do not yet have evidence from research trials, he added.

Ultimately, the aim is to create a resource that provides a clear and detailed overview of what needs to be done as well as providing the available options and tools to implement the plan, Kohrt said. He illustrated this with the example of case finding. There are various existing models of case finding, some of which are using universal screening with existing tools; these include the Community Informant Detection Tool and the Rwanda model, in which idioms of distress are used for targeting. Ideally, implementers would be provided with information about multiple types of case-finding models for a CHW to use and then be able to choose which model(s) might be implementable based on the setting. At that point, considerations include where to do the screening and whether there is an existing, validated screener tool.

### 3.3.4 Common mental disorders versus severe mental illness

Kohrt highlighted the critical distinction between CMDs and SMIs. He recommended being explicit in the guidance that CMD services do not necessitate an extension of SMI services, nor are they simply tacked onto the existing SMI system (although there may be a certain degree of overlap). It is also worth considering whether CMD services should be tacked onto models of care management for noncommunicable diseases, such as diabetes or hypertension, because those models will be much more effective. “You still have SMI treatment that you need,” he added, “but you don’t use SMI treatment as your starting point.” The group discussed how a non-health entry point also needs to be built into the system as an alternative or complementary pathway. Creating these pathways will require engaging with key stakeholders and existing systems, such as ministries of education or social welfare; it is important to work through multiple channels including school programs and focus groups. Kohrt also cautioned against messaging that conflates CMD with SMI, because this may undermine the process and further stigmatize conditions that are not recognized in the setting’s existing health systems and cultural contexts.

### 3.3.5 Discussion

#### 3.3.5.14 Training and supervision

Abhijit Nadkarni observed that training and supervision are missing from the framework. Kohrt replied that mapping the existing training resources in place would be a component of the landscaping activity. The landscaping would also include the level of trainings that CHWs have had as well as any competency assessments. In terms of compensation, he questioned whether compensating a CHW to attend training would have implications on the CMD case finding and delivery of care. Nadkarni asked if training and supervision would be one of the CHWs’ activities. Being a supervisor or being involved with supervision is a task
and role that CHWs have to include in their work plan, agreed Vikram Patel, of Harvard Medical School (USA) and Sangath (India). CHW training and supervising each other is not very common in literature or case studies, said Kohrt, other than in the context of peer supervision, awareness raising, health talks, and psychoeducation. It would be helpful to see evidence for CHWs involved in a training role, he added.

3.3.5.15 Community health worker roles beyond individual patient care
Patel remarked that much of the framework is focused on individual patient care; he suggested that the group consider CHW roles at an aggregate level beyond individual clinical care. Prevention and promotion, for example, have very strong community components as well as individual components. At the health system level, he suggested considering where supervision and training would fit.

3.3.5.16 Dimensional approach for mapping community health worker tasks
Patel suggesting mapping CHW skills or tasks using the dimensional approach, which spans promotion, prevention, case finding, enrolment, and engagement. The first two and perhaps the third fit into a generic set of skills that every CHW should have, such as how to promote mental health, how to identify cases, and so on. The next set of skills or tasks might only be for very skilled or accredited CHWs (e.g., certain diagnoses or clinical interventions). Kohrt replied that this idea was raised in the context of different scenarios, including one in which all existing cadres are responsible for certain skills while a select sub-group of the cadre is also responsible for an additional set of specialized skills. However, he noted that this would require a government to consider creating a new cadre of CHWs to take on the tasks. He added that it will take work and expertise to enable CHWs to safely deliver this care, some of which would fall under the auspices of training and supervision recommendations.

3.3.5.17 Basic support by community health workers
Giuseppe Raviola (Harvard Medical School and Partners In Health, USA) highlighted the commonalities between this group’s work and the working group on systems. The group discussed the spectrum that has been described by Patel—from wellness to stress to depressive disorder and then recurrent depressive disorder—that moves it from the community toward the health center. They also talked about the importance of mental health promotion, self-care, community solidarity roles, screening, psychoeducation, prevention, and referral. However, the topic of basic support became more controversial. In Ethiopia and South Africa, for example, basic support is not feasible after the transition from an NGO activity funded through another source to a public sector budget. Addressing this will require persuading ministries of health that CHWs can and should provide that basic support.

Raviola asked about the role of innovation and guidance in pushing the boundaries around what CHWs do in terms of basic support, given the evidence that they can provide such support. Patel welcomed suggestions for innovation and hoped that the output of the workshop would be an optimistic statement in contrast to the field’s typical nihilism and focus on barriers. The message should use what has been done already to support what should be done going forward, which can include innovations and knowledge gaps. Standard practice versus innovation could be differentiated in different categories, added Raviola. From her perspective as an implementer, Hildegarde underlined the need for innovation around quality of the existing mental health service.

3.3.5.18 Tension between vertical services and universal care
Inge Petersen (University of KwaZulu-Natal Centre for Rural Health, School of Nursing and Public Health, South Africa) noted the tension between vertical services and the move toward universal and people-centered
care. In the HIV community, funding has created a donor-driven vertical service on the ground, which is becoming a problem. In South Africa, for example, they want an integrated program to deal with multimorbidity. This tension needs to be exposed and dealt with, she added, in order to avoid creating these types of vertical services. Kohrt suggested indicating in the group’s model that a horizontal rather than vertical approach is preferred, given South Africa’s HIV experience. That would enable appropriate planning from the outset for a horizontal rather than vertical system. Patel replied that recommendations have to be based on what can be done with the existing health worker model because recommendations based on new workers will be dead in the water. In India, for example, there are already a million workers on the ground, a large proportion of whom are doing nothing because the ongoing epidemiological transition has made redundant what they were initially trained to do. Those million workers need to be redeployed to work in the noncommunicable disease and mental health spaces. However, he conceded that those might be alternatives in different countries and contexts where the system is absent or fragmented.

3.3.5.19 Community health worker versus community worker

Rabih El Chammay (Saint Joseph University, Beirut and National Mental Health Program, Lebanon) drew a distinction between CHWs and community workers. He suggested that CHWs could be hosted by other platforms in various social or educational sectors, for example. The discourse is currently framed by placing CHWs only in the health sector, he added, noting that there may be resistance to putting those CHW human resources in the other sectors. In that vein, he wondered if a similar landscaping analysis of those social and educational systems might serve as potential platforms. “If we want that we need to take a step back from community health workers and think differently,” he said. The plans being discussed require high expertise and countries lack the resources to create these new systems. To address this, it might be helpful to provide guidance for government authorities about the minimum skillset we expect this type of complex undertaking to require.

3.3.5.20 Landscaping activity support, scope, and target audience

Dan Palazuelos (Harvard Medical School and Partners In Health, USA) described the landscaping function as a critical part of the process. The first step is to understand what the context is, to assess what is available in terms of workers inside the health sector or outside, to examine the granularity, and to determine what needs to happen before starting to build out a system. While this will vary by context, common themes do emerge. In reality, most governments will not be able to do this well on their own. The Community Health Impact Coalition is a group trying to serve a supporting role by collaborating with governments to landscape, identify and evaluate options, and move forward through the maze of political negotiations. The product is a functioning system and not a set of recommendations. Kohrt added that in cases where even the landscaping activity is beyond the scope, there will be feasibility issues around collecting the information to design the program. El Chammay agreed that it is crucial to gain a proper understanding of all the system at play in a country, not only the health systems, in order to integrate mental health. During landscaping exercises and situational analysis, it is important to include other actors as well as other ministries, added Inka Weissbecker (International Medical Corps, United States). Such actors might include civil society organizations, service-user organizations, and peer-to-peer support networks that are already doing case finding or providing basic support, for example.

El Chammay also commented on allowing for flexibility in the target audience as appropriate for different contexts. In Lebanon, for example, CHWs are actually under the mandate of the ministry of social affairs, so it would be a
mistake to target the ministry of health. He also suggested adding a piece within situation assessment to create a government structure to facilitate collaboration and coordination between different ministries to promote the overall mental health policy of the country. This allows for flexibility at the national level in terms of which ministries to address and engage most productively. In terms of utilizing existing services, Madi suggested bringing that cost-efficiency dimension to policymakers because it is the most efficient approach. She added that the issue of integration is linked to universal health coverage.

3.3.5.21 Risk of overburdening community health workers

In response to Patel’s comment about deploying existing CHWs, a participant asked about the tipping point in terms of adding tasks to the CHW’s remit: at what point does the CHW exceed the threshold of work he or she can accomplish? This is a particular concern if CHWs will be asked to deliver psychological therapies in addition to case management, referral, and so forth. Kohrt replied that competency assessment or competency guides could provide a sense of what is expected at each level. However, situations may arise where the care will not only be ineffective, but will be unsafe. He suggested that this type of process could provide guidance about how to address such situations; if expanding the workforce is not an option, then solutions other than adding more tasks will be required (such as moving to other sectors). He worried that this process would be so idiosyncratic to each system that the landscaping itself would become such a lengthy and effortful process that implementation will be delayed indefinitely.

Kohrt pointed to a tension between knowledge and action in the field and asked participants to consider the middle ground—that is, what would be “good-enough” principles to include in the guidance to make it a feasible, helpful process rather than requiring an onerous process that impedes implementation due to the level of granularity required. Christian Rusangwa (Partners In Health/Inshuti Mu Buzima, Rwanda) remarked that government entities can be siloes that compound these problems. He noted that in Rwanda, ministries of health, communication, security, and local governments meet regularly to address some of those issues. They are able to find funding for issues like CMDs and pull resources together. When CHWs become overburdened, they can float some of the work to other workers (e.g., social workers). Kohrt suggested developing a feasible consultation process to bring to different governments in a supporting function.

3.3.5.22 Community health worker polyvalence

Patel called for retaining the focus on the CHW and whichever platform in which he or she is deployed. Although the skills being discussed have obvious generalizability to many other platforms, addressing all those other platforms is beyond the scope of the workshop because the platforms have such different ways of being developed. The current audience is ministries of health and NGOs that work in the health sector. However, he suggested the role of health sectors working with other sectors could be flagged in enabling systems by the third working group on systems and strategies for integration.

What the health worker is expected to deliver should be a pure set of activities or tasks based on understanding of the evidence. The practical implementation must be enabled by the system, he added. If CHWs become overburdened, then something has to give: “... maybe you need additional health workers or some other model. But they still remain the core tasks that you think a community health worker should be able to perform in this area of depression and anxiety.”

3.3.5.23 Social determinants of common mental disorders

Raviola reported that his group discussed the role of CHWs in addressing the social determinants of CMDs and facilitating solidarity as part of the package, without
overidentifying CMDs with those determinants (such as domestic violence and alcohol use). Haifa Madi remarked that mental health programs are well suited for a multi-sector approach, because the impact of social determinants of mental health are crosscutting: violence, injuries, trauma, emergencies, and others.

A participant recommended mainstreaming and positioning mental health and disability across sectors (such as health, social, education, health, labor, etc.) in order to drive the national strategy and avoid becoming entrenched in vertical, sectoral-specific strategies. This positioning is dependent upon both framing and verbiage. In Dubai, this was accomplished by talking about wellbeing of the population rather than mental health, which achieves strategic outcomes of social cohesion, family and social inclusion, and general wellbeing and happiness. Through that, they established a Minister of Happiness who is mandated to ensure that this agenda spans all the relevant stakeholders and is not only attached to one sector, like the health sector.

3.3.5.24 Balancing quality and feasibility

Mark Jordans commented upon another tension around wanting quality and looking for feasibility. While it is important to be aspirational and optimistic, working within the constraints of an existing system will not provide the quality that we want. He suggested thinking outside of the box about what extra cadres of people will be needed to be able to deliver that quality of care, particularly with respect to psychological treatments that should probably be delivered outside of a health facility. Deliberations about who should deliver those treatments should be aspirational and not confined by those constraints of the existing system, especially in low-income settings. Innovation is a good way to capture that, he added.

Kohrt concluded the discussion by summarizing some key points from the discussion (see Box 32).

Box 6. Recommendations on community health worker roles

Kohrt summarized a set of recommendations gleaned from the first large-group discussion on community health worker roles, tasks, and polyvalence:

- Ministry of health involvement is non-negotiable, especially for training and supervision.
- Create a “CHW model plus” program.
- In promotion, prevention, and case finding, map out allies in the process (e.g., teachers and law enforcement) and what they are doing; consider as well as what CHWs could ideally be doing in collaboration with other sectors
- Some activities may be better suited for a mid-level aspect of the health system, or the level of quality may not be acceptable.
- Social determinants affect depression.
- Innovation can still happen.
- Establish the bare minimum set of competencies a CHW should have.
3.4 WORKING GROUP ON COMMUNITY HEALTH WORKERS ROLES, TASKS, AND POLYVALENCE: SECOND SESSION

Brandon Kohrt and Dan Palazuelos reported out from the second session of the working group on CHW roles, tasks, and polyvalence. They used Figure 16 to frame their presentation. Before describing the specific roles, Kohrt explained how they mapped out the systems or stages of an example mental health infrastructure within a country. Based on the stage, there may be appropriate or potentially inappropriate activities for a CHWs at each stage. He noted that this is just the beginning of a potential framework and it is very flexible.

Figure 16. Potential framework for community health worker roles and tasks

This type of exercise should begin with a landscaping activity or situational analysis to explore the following characteristics of the setting:

- Scope of problem, including burden of disease and local priorities (suggested sources: WHO-AIMS and national data)
- Conceptualizations of CMDs: values, attitudes, and current treatment seeking (suggested sources: qualitative interviews)
- Community resources and support, including families, livelihood, religious groups, traditional healing, social services, service-user groups, and human rights groups (suggested sources: social welfare registration, qualitative interviews, stakeholder meetings)
- CHW landscape: who are they, their place in the health system, what tasks they do, how they are trained and certified, education qualifications, and regulations
for scope of work (suggested sources: Ministry of Health or other relevant ministries, direct discussion with CHWs)

- (Mental) health system landscape: available care, providers, training and supervision resources, referral receipt centers, physical structures, medications, technology, data/HMIS (suggested sources: Ministry of Health, direct discussions, service-user meetings)

- Actors, policy, and funding: funders, priorities, policies, commissions, champions, advocacy, national groups (suggested sources: stakeholder meetings, WHO desk reviews in humanitarian settings guidance)

The working group also sketched some principles of design for CHW roles (see Box 7).

**Box 7. Principles of design for community health worker roles**

According to the working group on community health worker roles, tasks, and polyvalence, the following are some principles of design to bear in mind with respect to roles:

- Horizontal integration (not vertical systems), not parallel systems
- Commitment of Ministry of Health
- Collaboration with other ministries and sectors
- Assure basic tasks are provided
- Assure adequate training and ongoing supervision
- Do no harm approach and assure minimal competencies
- Health and non-health entry paths versus only severe mental illness entry paths
- Non-stigmatizing entry: wellness, stress, tension, thinking too much

*Source: Harvard Medical School Center for Global Health Delivery-Dubai, Working group on community health worker roles, tasks, and polyvalence 2018b.*

### 3.4.1 Description of stages

Kohrt provided an overview of the three stages proposed by the group.

At **Stage 0**, there would be absolutely no mental health resources available in the country: no primary healthcare workers have been training and there are no psychiatrists 8 hours or even 20 hours away. No resources are in place to access mental health services.

At **Stage 1**, there is access either to specialists (such as psychiatrists or psychologists) or mental health trained workers, such as mhGAP trained primary care workers.

At **Stage 2**, mental health services are present, coupled with adjustments to the obligations and work load of the CHW. At this stage, resources for accessing mental health are in place and there is also coordination with government and local administrators with regard to reasonable protection of the CHWs’ time. The CHWs have a reasonable workload and size of their assigned geographic regions has decreased; the incentivization process has also been adjusted and there is some supervision available.

At **Stage 3**, all the conditions of Stages 1 and 2 are in place, in addition to psychological services supervision plus competency-based selection for psychosocial and psychological skills. Resources are in place, as well as even greater protection of CHWs’ time to take on
low-intensity psychological services and lower ratios of CHW per population. Kohrt noted that the transition from Stage 0 to Stage 3 may be a 25-year process or a ten-day process, depending upon the context. For example, during a humanitarian crisis, the transition may be very swift due to the amount of resources coming into the country. This will not always be a gradual process. The system may also attain conditions of Stage 3 prior to Stage 2, so the framework is not overly concrete or sequential.

The group was tasked with answering the following questions: what would be good enough to do, what should be done, and what should not be done? Kohrt and Palazuelos broke this down for each of the four stages.

3.4.2 What would be good enough to do at each stage

Kohrt began with what would be good enough for CHWs to do at each stage. At Stage 0, the group discussed whether it would be appropriate to train CHWs on detecting CMDs when there is virtually nothing they could do about it. This gives rise to multiple ethical concerns and may place an undue burden on CHWs. At this stage, there may be other activities that could be initiated, such as mhGAP trainings or similar, but the group did not recommend creating a formal role for CHWs with respect to CMDs at this stage.

At Stage 1, it would be good enough to introduce activities that CHWs can integrate into their existing practice. Ideally, there should be no additional time burden or additional home visits required of CHWs, but if they encounter cases in their day-to-day activities, they would have the skills in place to respond appropriately. At Stage 2, it would be good enough for CHWs to take on a greater set of tasks and roles, because now they have the time and are receiving the incentivization to appropriately administer those tasks with quality. At Stage 3, it would be good enough to put additional supervision to enable adding a larger number of roles to the CHWs’ activities.

3.4.3 What should be done at each stage

At Stage 1, it would be good to introduce discussions about CMDs into the CHWs’ existing health talks (but not adding new ones) as well as integrating psychoeducation into patients’ healthcare. CHWs should be able to recognize signs and symptoms of CMDs when doing home visits and be able to carry out passive case finding with CIDT, as opposed to proactive case finding. If they come across cases they can make a referral, but they are not making additional home visits at this stage. In addition, CHWs are working with families where there may be CMDs, making referrals, administering psychological first aid, and responding to psychiatric emergencies.

The latter is critical, even at this early stage, because CHWs will inevitably encounter suicide attempts, suicidality, and other psychiatric emergencies; having a protocol to respond is important. CHW wellbeing should already be included, rather than waiting to introduce it at later stages. Advocacy is also important from the very beginning. Common factors and engagement skills should be a part of the Stage 1 training, because this will support CHWs who are caring for HIV/AIDS, maternal and child health, and other noncommunicable diseases. Linkage is also crucial at Stage 1, both to formal and informal services, including with linkage and collaboration with service users.

At Stage 2, the time and appropriate incentive structure are in place to be able to integrate more independent CHW activities related to CMD. These include running CMD-specific community incentivization, trying to increase mental health literacy, carrying out stigma reduction activities, using screening tools and/or proactive case finding (i.e., doing additional visits and generating referrals from the demand side), CHWs should also do follow up and adherence tracking as well as working with defaulters. At this stage, CHWs would have more resources and check lists to monitor medication side effects, do case management, and then provide instrumental
support. They should also provide psychosocial rehabilitation and vocational support to address some of the social determinants of CMDs.

At Stage 3, the additional protected time as well as the resources in place should enable CHWs to implement low-intensity psychological interventions—the Thinking Healthy program, PM+, or another intervention appropriate to their skill levels. The group did not anticipate that at Stage 3 this would be universal to every CHW, which is why they included competency-based selection procedures to determine the CHWs who would be most suited to delivering these Stage 3 activities. Stage 2 should ideally comprise the activities that every (or almost every) CHW should do, but not every CHW will be able to effectively and competently able carry out the Stage 3 activities (see Figure 17).

### Figure 17. Community health worker core tasks and optimal tasks

<table>
<thead>
<tr>
<th>Core Tasks (all CHWs)</th>
<th>Example activities</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention and promotion</td>
<td>Human rights promotion; stigma reduction</td>
<td>Child/adolescent studies; Adult studies</td>
</tr>
<tr>
<td>Case finding</td>
<td>Screening, proactive case finding, symptom recognition</td>
<td>Screening?; CIDT</td>
</tr>
<tr>
<td>Enrollment/engagement</td>
<td>Awareness raising; Accompaniment; Emergency engagement (suicide)</td>
<td>VISHRAM; Emergency review (Abhi)</td>
</tr>
<tr>
<td>Follow-up &amp; support</td>
<td>Adherence; defaulters; family engagement/education; monitor side effects</td>
<td>Tech review (John)</td>
</tr>
<tr>
<td>Reintegration/linkage</td>
<td>Social/economic inclusion; intersectoral work; SU collaboration</td>
<td>???</td>
</tr>
<tr>
<td>Self-care</td>
<td>CHW burnout prevention, etc.</td>
<td>???</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Optimal Tasks (Select CHWs)</th>
<th>Example activities</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment (manualized)</td>
<td>THP/P, [training, supervision, time]</td>
<td>Singla 2017</td>
</tr>
<tr>
<td>Training/supervision</td>
<td>Training and supervision of other CHWs; train community partners</td>
<td>???</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Harvard Medical School Center for Global Health Delivery-Dubai, Working group on community health worker roles, tasks, and polyvalence 2018b.

### 3.4.4 What not to do at each stage

Kohrt and Palazuelos also suggested what should not be done by CHWs at each stage. For Stage 0, the group advised against screening campaigns because there are no places to refer; nor should there be pharmacological management or mass awareness raising. However, existing resources—including informal resources—should still be used.

CHWs may already be doing referrals to religious leaders or similar and should continue doing so.

At Stages 1 and 2 it is not appropriate to do manualized psychological treatment, due to concerns around competency and supervision. At Stage 1, activities should not be included in program design that would require additional time of CHWs without
the protective financial and scope of work rearrangement. Across Stages 1, 2, and 3, designers should ensure that CHW programs horizontally integrated and not vertical; CHWs should not play a role in initiating pharmacological treatment at any stage.

During the subsequent discussion, a participant noted that at Stage 3 it is not recommended to initiate medications. But because mhGAP is associated with prescribing medications, the participant asked if mhGAP would be done at Stage 3. Palazuelos replied that theoretically, primary care workers would be initiating medications by Stage 1. The group felt that CHWs should never initiate medications because it is beyond their purview. The fundamental tenet of the model is to try to get CHWs to increase community mental health services—it is not the end goal to have CHWs who set up a shingle and are running a shop where they are doing all of these services. At stage 3, these processes are not institutionalized. Ultimately, the goal is that the services remain community-based services even at the highest level of specialization.

3.4.5 Financial implications at different stages

Kohrt described some of the financial implications at each of the stages. At Stage 1, the additional costs incurred might include some training and supervision, but they would be relatively minimal. Stage 2 would incur higher costs as the CHWs scope of other activities is reduced and mental health activities are added on. At Stage 3, increasing amounts of time devoted to psychological treatments requires ensuring that other services are still being done. Trying to integrate non-incentivized psychological services with other incentivized-based outputs will not generate the needed outputs, he warned. He explained that the cost to progress through the stages is contingent not only upon the cost of the activities, but also their cost effectiveness. Presumably, the number of people being reached and the type and severity of CMDs that can be treated will increase at each stage and compound the costs. For policy makers, planners, and funders, it may be helpful to calculate numeric values for each stage’s cost effectiveness.

In terms of the return on investment, Palazuelos remarked that at each stage, “as you invest more, you get more return. That makes a stronger argument to go up to scale and not just settle at a stage. It’s aspirational to keep progressing.” Kohrt added that the return on investment at Stage 2 or 3 would be highest, because of the degree with which you produce positive results and the number of people that can be treated.
4 Community health worker recruitment, training, and supervision

4.1 INTRODUCTION

Chapter 4 provides a summary of content related to community health worker (CHW) recruitment, training, and supervision. This includes the review presentation, reflections from the panel of expert implementers, report backs from two sessions of the working group on the topic, and input from the large-group discussions.

This working group’s goal was to define scalable approaches to recruitment, training, and supervision of the delivery of CHW interventions for common mental disorders (CMDs). The group was asked to explore ways to train CHWs to deliver CMD interventions in a scalable way, for example, reducing the disruption to existing CHW roles and the reliance on mental health professionals. They discussed ways to assure quality of CMD care in routine health care services in a scalable way as well as the essential characteristics of CHWs that make them suited to the care for CMDs. Potential barriers to effective training and supervision were highlighted along with possible ways to address them. They contemplated issues related to health workforce management, wellness, and self-care that should be addressed in the development of a holistic model for CHW-focused care of CMDs. The potential role of digital platforms in training and supervision was also considered by the group.

4.2 LESSONS LEARNED FROM TRAINING AND SUPERVISING NON-SPECIALIST PROVIDERS: REVIEW PRESENTATION

Singla, a clinical psychologist and clinician scientist who is an assistant professor and distinguished fellow in the Medical Psychiatry Alliance in the Department of Psychiatry at the University of Toronto. Singla was tasked with discussing some of the lessons learned from training and supervising non-specialist providers in low- and middle-income countries (LMICs). She discussed some lessons from a 2017 review on CMDs, as well as presenting case studies on the Healthy Activity Programme (HAP) and the Thinking Healthy Programme by Peers54 (THPP-P).

4.2.1 Review of psychological treatments for common mental disorders in low- and middle-income countries

Singla provided a broad overview of training and supervision using the 2017 review55 that examined the effectiveness of non-specialist delivered psychological treatments in LMICs. The aims of the review were to examine the “who,” “what,” “where,” and “how” of psychological treatments—that is, the implementation processes—including an examination of training and supervision processes. The review included 27 randomized controlled trials from 17 countries. To be eligible for inclusion, studies had to be randomized controlled trials of adults aged 18-65 years, with a focus on non-specialist-delivered treatments for CMDs including depression, anxiety, and trauma in LMIC settings.

4.2.1.25 Who provides the intervention?

Singla explained that CHWs fell under the general definition of non-specialist providers (NSP). Non-specialists include anyone who

55 Singla et al 2017
provides or is intending to provide mental health care but has not had specialized professional clinical training in a field closely related to mental health. Singla emphasized that CHWs were the most prominent NSPs delivering treatments. One-third of the trials included in the review had interventions that were implemented by CHWs who were formally employed by the government through the health system, she noted (see Figure 41). The other frequently used personnel were peers or individuals specifically recruited for the trial from the same community (29.6%), nurses (18.5%), and midwives (14.8%).

Figure 18. Providers delivering the interventions

4.2.1.26 How: processes related to intervention implementation, including training and supervision

4.2.1.26.8 Training
Of the 27 trials, 18 reported statistics on training. The majority (14/27) used a mixed method approach of didactics plus practice, including the apprenticeship model. The duration of training ranges from three hours to two months, with an average of about 10 days (78.8 hours [95% CI = 21.8 to 135.8]). However, Singla noted that if Patel’s trial is excluded in calculating the average, the average training length drops to 53.8 hours—which is similar to the finding from Kohrt’s review which found that CHWs had roughly two weeks of training. Data are missing from many of the trials in the review, said Singla. For example, nine trials did not report at all on training methods and no trials reported on competency, evaluation, or certification; only six studies (23.8%) reported on some
assessment of fidelity with respect to training and supervision.\textsuperscript{59}

4.2.1.26.9 Supervision

More data are missing in the area of supervision, said Singla, although a slightly greater number of trials reported data on supervision than training. Of the 27 included trials, 15 reported data on supervision format, 19 on supervision methods, 17 on the person in the supervisor role, and 17 on the frequency of supervision. In terms of supervisor format, all those reporting data conducted supervision in person, either in groups (86.7\%) and/or individually (66.7\%).\textsuperscript{60} Less than half reported using technology to supplement supervision (46.7\% telephone and 40\% via Skype). The most common methods of supervision was through case review (63.7\%), observed sessions, and listening to audio sessions.\textsuperscript{61} The supervision was typically conducted by an expert only (76.5\%) or with others (17.6\%); only one trial reported supervision by peers only.\textsuperscript{62} Most of the RCTs who reported on supervision frequency conducted weekly supervision, three had ad hoc supervision, and one trial had monthly supervision.

4.2.1.26.10 Role of specialist

All included trials provided data on the role of mental health specialists. Singla pointed out the heavy reliance on mental health specialists to provide supervision, noting that the primary role of the specialist/expert was that of trainer or supervisor.\textsuperscript{63}

4.2.1.27 Lessons

According to Singla, the review demonstrates that lay counselors or NSPs can effectively deliver manualized treatments for CMDs in developing countries. However, specialists are still required to supervise and assess the quality of these treatments. Further, competency is rarely reported and systematic methods are lacking. The review also highlights the lack of digital platforms to enhance supervision and the large swathes of missing data, particularly around training and supervision. She also noted that since the review was completed, at least four additional trials have been published.

4.2.2 Therapy quality and competence

Singla used case studies of HAP and THP to highlight the importance of the constructs of therapy quality and therapist competence. She defined therapy quality as the extent to which a treatment was delivered well enough for it to achieve its expected effects—“doing the right things well.”\textsuperscript{64}—which is assessed by rating individual treatment sessions. Therapist competence is the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects; in other words, it is the therapist’s capacity to provide a treatment at an acceptable standard. This is assessed by rating of standardized role plays.

4.2.2.28 Healthy Activity Program scale for assessing therapy quality

Singla explained that the HAP is a contextually-relevant behavioral activation psychological treatment that has been delivered by trained, lay counselors and has been shown to be effective in reducing depressive symptoms with sustained effects in Goa, India.\textsuperscript{65} Lay counselors were recruited

\textsuperscript{59} Singla et al 2017
\textsuperscript{60} Singla et al 2017
\textsuperscript{61} Supervisor methods (n=19): case reviews (12); audio sessions (2); observed sessions (5); not specified (8)
\textsuperscript{62} Singla et al 2017
\textsuperscript{63} Role of specialist (N=27): trainer (18); supervisor (17); medication (4); send referrals (3); receive referrals (7)
\textsuperscript{64} Fairburn and Cooper 2011
\textsuperscript{65} Patel et al 2017; Weobong et al 2017
and trained in the HAP, with an average age of 25.9 years and 15 years of education. They were trained and supervised over three months using a three-stage protocol.

She explained that within the HAP, they developed a scale to assess therapy quality for culturally-adapted treatments for depression (HAP). They assessed quality by listening to and rating individual audio sessions for treatment-specific skills as well as general skills. Treatment-specific skills—that is, skills specific to the HAP intervention being delivered—included 7-11 items (rated on a Likert scale of 0 ‘not at all’ to 4 ‘excellent’), depending on the phase of treatment. Example skills include employing the HAP model, reviewing and setting the session agenda, and involving the significant other. General skills are common skills or the general approach that the counselor displays in an individual treatment session: e.g., using a collaborative approach, practicing active listening, and using a non-judgmental approach. This was assessed using ten items rated on a Likert scale of 0-4. A study was developed and implemented to determine if lay counselors can be trained to evaluate their peers just as well as their supervisors, which would reduce the need for specialist care workers as well as mitigating the reliance on experts for supervision.

The format of therapy quality assessment was weekly group meetings of two to four sessions, which typically included four groups of five lay counselors plus one expert supervisor. The group would listen to the audio session and rate the counselor according to the scales, then the supervisor provided feedback. Audio sessions were selected for assessment based upon the quality of the audiotape, the distribution of sessions across beginning, middle, and end phases, and the distribution of sessions across counselors. They found that by the end of the trial stage, peers were able to evaluate their sessions as reliably as the expert supervisor, both in terms of treatment-specific skills and general skills (see Figure 19).
Figure 19. Therapy quality in Healthy Activity Program

Source: Singla. Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018.
4.2.2.29 Thinking Healthy Programme – Peer-delivered

Singla explained that the peer-delivered version of the Thinking Healthy Program (THP-P) addresses the human resource barrier by training peers to deliver the program, thus attenuating the burden placed upon CHWs, such as lady health workers. The THP-P adaptations to content include an emphasis on behavioral activation, standardization of general health messages, use of vignettes and narratives, use of job-aids, and simplification of language. Adaptations to delivery include reduction in the number of sessions as well as cascade training and supervision.

In India, the THP-P is delivered by “Sakhi” over 6-14 individual sessions; each peer received training of 25-40 hours in total (3-4 hour sessions of classroom-based training) followed by approximately two months of clinical internship (2-4 sessions) and then refresher training. In Pakistan, THP-P is delivered by “Razakaar” over ten individual sessions and four group sessions. Peers received five days of classroom-based training, six months of clinical internship during the pilot, and a two-day refresher training prior to the trial. She noted that there were differences in the numbers of sessions provided to mothers with depressive symptoms and both sites involved the didactics and practice model previously mentioned.

Singla provided more detail on the delivery of THP-P in India. Peers were trained in THP-P as well as the 18-item Therapy Quality Scale (TQS; adapted from PREMIUM [the HAP trial] and ENACT). They sought to determine whether peers could be trained to rate the therapy quality of their own peers’ treatment sessions as reliably as expert raters. Ultimately, the study found that lay counselors were able to reliably rate their own sessions and at one year, the differences between peers and experts were minimal. However, this required making some critical adjustments mid-course. After eight months, they were finding large, significant differences in the mean TQS ratings between experts’ ratings and peer ratings. This problem needed to be resolved because supervision was a bottleneck that needed to be addressed. The expert intervention team analyzed each item for accuracy and consistency, including language used in the TQS. They analyzed the Sakhis’ perspectives in terms of specific items and their relationship to the overall program. They provided extra training to Sakhis on the TQS and the supervision method was modified: audio was stopped and discussed in chunks, instead of being listened to all at once. A year after the process was adjusted, the discrepancy between peer and supervisor ratings were reduced to an acceptable level (see Figure 20). Singla emphasized that if peers can rate their own sessions as reliably as experts, it will reduce the overreliance on specialists for supervision, as was seen in many of the trials in her group’s review article.
**4.2.3 Conclusions**

Singla concluded that based upon the majority of existing data, there is a bottleneck of training and supervision, namely the reliance on expert specialists. Specialists are still required to supervise and assess the quality of these treatments. She underscored the need to measure and report how competency is assessed using systematic methods and reliable tools—there are tools that exist, but there is still much work to be done. Finally, digital platforms can be used to enhance supervision and improve the scalability of evidence-based psychological treatments, but this has yet to be done in the realm of training and supervision.

**4.3 PANEL: IMPLEMENTERS’ EXPERIENCES IN COMMUNITY HEALTH WORKER RECRUITMENT, TRAINING, AND SUPERVISION**

Singla moderated the panel on implementers’ experiences in CHW recruitment, training, and supervision. The panel of expert implementers was asked to discuss ways to train CHWs to deliver psychological therapies in a scalable way (e.g. reducing the disruption to CHW existing roles and the reliance on mental health professionals) and how to address the reliance on expert supervisors to improve the scalability (and sustainability) of non-specialist delivered psychological treatments. They also reflected on ways to assure the quality of therapy delivery in routine health care services in a scalable way, beyond clinical trials.

The panel included:

- Laura Murray (Johns Hopkins University, Bloomberg School of Public Health, USA)
- Lena Verdelli (Columbia University Teacher’s College, USA)
- Anne Becker (Harvard Medical School, USA)
Laura Murray is an Associate Scientist at Johns Hopkins University School of Public Health in the Department of Mental Health and International Health. A clinical psychologist by training, she is a co-founder of the Applied Mental Health Research group, which has developed and refined a Design, Implementation, Monitoring and Evaluation (DIME) methodology for use with mental and behavioral health initiatives in low-resource countries. She has led two randomized controlled trials of Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) with children and adolescents in Zambia examining effectiveness, implementation and HIV-related behaviors. She is co-developer of the CETA approach: a modular, flexible multi-problem transdiagnostic approach built to address implementation barriers. One of her primary research areas is implementation science in low-resource countries, examining feasibility, acceptability, fidelity and sustainability, and the effectiveness of implementation strategies for the wider system of care.

Murray framed her comments within a systems approach, suggesting that one of the critical ways forward for scalability and sustainability is the linkage of care from what has been described as “tier one” (e.g., primary prevention), which usually requires fewer resources and reaches many, and leads into and connects with “tier 2” treatment of CMDs. Scaling up and sustaining treatment involves supervising people day in and day out in the field. Due to the many real-world comorbidities and the non-static condition of human beings, her team has transitioned to the transdiagnostic approach – rather than a focal approach where one might learn to treat only depression or only substance abuse. In terms of training and supervision, therefore, they are trying to teach clinical decision making. There was a question in the field whether this could be taught to lay providers with transdiagnostic work, but recent work has shown that it is possible to train lay providers in clinical decision making. Training providers in just one approach is more sustainable and scalable than training providers in the 8-10 approaches or treatments that might be needed to cover multiple disorders and related problems (e.g., violence).

The measurement of competency and time to competency is one of the main problems, said Murray. More reporting from researchers and programs about the clinical side will be hugely important going forward—such as how many days of training providers actually received and how much time they actually spend with clients. She surmised that if this data were available and compared, information about low- versus high-intensity training, for example, would be better understood. If competency measurement is not achieved soon, then training and supervision will essentially remain a question. Workers are going out and treating people without the support they need, due to quibbling about how to train them. However, without a validated competency measure, it will be very difficult to make decisions about how much and what type of training is good, or “good enough”.

As a clinician, she is concerned about the public health push toward shorter, better, less human, less supervision, and shorter training. Based on her experience talking to people day in and day out, providers in the field are craving more supervision. She called for a balance between getting faster at delivering care and reaching more people versus dealing with the severe issues patients and providers are facing.

Lena Verdelli is an Associate Professor of Clinical Psychology; Director of Clinical Training at Teachers College, Columbia University, and the Founder and Director of the Teachers College Global Mental Health lab. She played a key role in landmark studies over the past 15 years involving adaptation, training and testing of psychotherapy packages used by both specialist and non-specialists around the world and is the first author of the manual on Group Interpersonal Psychotherapy which
has been disseminated globally online by WHO. Verdeli urged participants not to forget the “C” in community health workers. Training needs to be a two-way street. As colleagues, CHWs bring to the table amazing expertise about what happens in the communities. Interpersonal psychotherapy focuses on the personal social determinants of depressive episodes and CHWs’ experiences are richer because they can provide information about reducing social isolation, livelihoods, activities in which the person is more functional, and broader issues such as domestic violence in the community. A sustainable, scalable model will need to apply the continuing education model. It is known that incentivizing CHWs beyond just financial compensation is important, and there are multiple ways to do so: providing certificates, opportunities for advancement, supervisory positions, and so forth.

Verdeli raised another issue related to therapy quality, which is related to adherence models—what is adherent therapy, and can people achieve it? She suggested that there should be a next level that addresses a different question—what is good enough adherence for good clinical data? Clinical trials in interpersonal therapy, for example, have found that consultation every two weeks for social workers was good enough in school-based clinics to have excellent and significant results.

Anne Becker is the Maude and Lillian Presley Professor of Global Health and Social Medicine at Harvard Medical School and is the founding and past Director of the Eating Disorders Clinical and Research Program at Massachusetts General Hospital. An anthropologist and psychiatrist, her areas of research focus include the social and cultural mediation of presentation and risk for eating disorders, social barriers to care for mental health disorders, and school-based mental health promotion. She has served as co-PI on school-based mental health interventions in Haiti and Lebanon.

Becker described some lessons learned during a school-based training intervention for depression and post-traumatic stress disorder for students in Haiti, through which educators were trained to be accompagnateurs to their students, within a task-sharing paradigm. They asked teachers to learn “the four Rs”: recognize, respond, refer and build resilience around mental illness. They offered the training to teachers in a retreat format for 2.5 days. In a didactic and interactive way, they were able to engage and empower teachers to imagine their role as educators in a different way—i.e., as strategically positioned to notice and respond when students were not doing well. Teachers were asked to build on their professional competencies to work as a liaison with the clinical care system. At the end of the training and implementation, they debriefed with the teachers about the gaps they perceived in the approach. First, the teachers’ responses indicated that the same drivers of scarcity that necessitate task sharing for clinical goals in low-resource environments may also constrain those with whom the tasks are shared. For example, teachers in these resource-constrained settings often had to cobble together multiple jobs, making small expenses important barriers when they wanted to get supervision and support—for example, they may not have had enough cell-phone minutes to contact the team, or a student with whom they were paired. Scheduling meetings to support students was also more challenging because their work sometimes required traveling from school to school.

With respect to the cultural environment, the constraints that are sometimes presumed to be barriers to mental health care seeking did not materialize. For example, although such putative cultural barriers would have suggested that students would not be interested in accessing mental health services, in fact, even students who had not been randomly selected for the study requested to join the program, suggesting they were eager to access care. Instead, the cultural issues related to school leadership—"we thought we
had engaged [them], but we hadn’t thought to engage and empower and train.” Teachers said that when principals did not understand the purpose of the study clearly enough, it was more difficult to obtain the space, resources, privacy, and time they needed for meeting with students. Also relevant to the cultural environment, there was a harsh punitive culture that undermined students; this underscored the need to pay attention and respond to the social adversities in the school environment. Many students were not getting meals at home, for example, which is a barrier to performing well in school. Students could also be punished for not having an up-to-date uniform or the right books, possibly leading to a suspension, which would compound the social adversities students faced rather than mitigate them.

According to Becker, the teachers’ responses suggested that the researchers imagine broadening the scope from a narrow focus on clinical care to providing social support to help students deal with social adversities. “Can you give us just a little bit in the way of resources, so we can supplement how we’re engaging students in mental health services with food or by repairing uniforms, for example? A hungry belly has no ear. We can’t work with the kids if their basic needs are not met.” Clearly, training needed to be bidirectional, said Becker. Such bidirectional training can lead to continuous quality improvement, that is, hearing back from the teachers and engaging and empowering. They asked the teachers to reimagine their role as teachers, and in turn, the teachers asked the researchers to reimagine and broaden their own roles as mental health practitioners to encompass social antecedents and precipitants.

Cidna Valentin is a training and quality improvement psychologist at Partners In Health | Zanmi Lasante (PIH | ZL). Cidna provides clinical support to the staff of 15 psychologists across 12 ZL sites and programmatic support to the ZL Mental Health leadership team based in Mirebalais, Haiti. She was hired to address complex comorbidities that psychologists were encountering, which challenged the task-shifting program. Hiring Cidna was helpful in addressing the complex comorbidities and supervising psychologists who are dealing with complex cases. She works primarily with psychologists, but related some of the things that CHW supervisors had shared with her.

As of June 2018, Haiti had 55 mental health CHWs, which had doubled over the previous two years (there are 2000 CHWs in the ZL system). Assessment of the former group of around 30 CHWs found that they derived a great deal of satisfaction from the work and found it meaningful and rewarding. They were instrumental in the delivery of mental health care, particularly for patients with depression, in implementing the first phase of IPT and delivering those services in a very effective way. However, CHWs were concerned about difficulties and barriers in receiving compensation that allows them to do the work with which they are tasked. Accessibility—that is, being able to travel to patients’ homes or healthcare facilities—is contingent upon CHWs receiving payments. “We know that CHWs can deliver care,” she said, “but the more pertinent question is how well we can support CHWs.” She pointed to another gap: as the demand increases for psychologists at the facility level, synergy will be needed between psychologists (who are becoming more specialized), and other roles. As psychologists in Haiti now have more opportunities to advance in their profession, she wondered whether conflict and tension will come into play in the context of task shifting and task sharing with CHWs.

Mark Francis Chalamanda is the mental health psychiatric clinical officer for PIH Malawi. He is responsible for all work activities related to mental health, including supervision and attending to patients with severe mental illness and epilepsy, as well as liaising with patients in the HIV program. He does not work directly with CHWs, although he has experience with the tools they use. There are about 1,020 CHWs in the Malawi PIH catchment area, whose primary roles are accompanying patients to health facilities for screening for tuberculosis, malnutrition,
and other conditions as well as household health education, including mental illness). CHWs are not providing psychotherapy yet, but they are mainly focused on treating people with psychotic disorders. In many parts of Malawi, people still believe that mental illness can be caused by witchcraft and are reluctant to bring people with mental illness in for treatment. CHWs can help with psychoeducation, accompanying patients to facilities, and helping with treatment adherence. CHWs receive five-day training followed by refresher training. This is not disruptive to the existing roles of CHWs. Ideally CHWs would be educated in a few carefully selected psychotherapy approaches they could use, he said, as they are concerned about overburdening them. Senior CHWs supervise other CHWs once a quarter using a checklist to assess gaps in treatment and to provide mentorship. For example, during their rounds, at the first house the senior CHW and the primary CHW visit, the primary CHW does work and at the next house, the senior CHW steps in more. If gaps are identified by the senior CHW, the primary CHW receives additional training and education. However, he noted that the senior CHWs themselves also need to be supervised. He also suggested that to ensure quality of therapy, they should use scales to assess the quality of services provided by CHWs.

4.4 WORKING GROUP ON COMMUNITY HEALTH WORKER RECRUITMENT, TRAINING, AND SUPERVISION: FIRST SESSION

Singla reported back from the first session of the working group on CHW recruitment, training, and supervision. The group discussed barriers to training and supervision, with the aim of defining scalable approaches to recruitment, training, and supervision of the delivery of CHW interventions for CMDs. The discussion was framed by questions around the essential characteristics of CHWs that dispose them to the delivery of care for CMDs, how to train CHWs to deliver interventions in a scalable way, and how to integrate quality-assured CMD care into routine health care services in a scalable way. They also discussed the potential role that digital platforms would play in training and supervision. She noted that due to time constraints, they were unable to discuss aspects of workforce management, wellness, and self-care that should be addressed.

4.4.1 Taxonomy of community health worker characteristics

In discussing the characteristics of CHWs related to recruitment, Singla said, the group distinguished between essential or desirable and “deal-breaker” characteristics. Based on existing research and participants’ experiences in the field, the working group sketched a list of essential or desirable characteristics that they considered to be important for CHWs, regardless of whether they are implementing a basic package or implementing specific psychological skills. The first is that the CHW comes from the same community in which they will serve, in addition to being respected and accepted by their fellow community members. They also suggested that CHWs have a minimum standard of education, which would vary according to the specific setting. They felt that mastering a set of common skills was essential for CHWs, which could be assessed via interview or standardized roleplay modalities. Other essential skills—which could potentially be evaluated through structured interviews—include good communication and interpersonal skills, positive affect, good capacity for empathy, ability to be non-judgmental, and organization and cooperative skills. She stressed the importance of considering contextual factors (e.g., age or gender) that underpin and influence the acquisition of those essential skills. The group identified a key gap with respect to the best way to systematically assess this set of skills through interviews or standardized, context-specific, requirement-based roleplay. The group noted that this assessment should be continuous and not limited to the initial recruitment interview. For example, further
assessment could be carried out during and after training, to determine whether the CHWs should be invited to participate in the implementation phase. According to Singla, the group suggested that deal-breaker characteristics might include lack of criminal record, commitment and sustained motivation, and language proficiency. She noted that how to assess the criminal record was identified as a gap.

4.4.2 Scalable community health worker training models

Singla said that during the discussion on training CHWs in a scalable way, the group agreed that conducting a needs assessment is essential to determine context-specific feasibility of training strategies. They sketched two different models of training (see Figure 44). The first was training CHWs in basic common skills (e.g., basic counseling skills, abilities to be empathetic and non-judgmental, and collaboration) as well as in core tasks, such as risk assessment, screening, and case finding. The second is higher-level training in basic skills related to psychological treatment packages and service delivery. Singla noted that the common skills and core skills may pertain more to the health prevention, promotion, and screening portion of the paradigm than the treatment-specific skills that are linked to a particular treatment or a particular package of treatments. Common and core skills are essential to not only the delivery of mental health, but to all basic behavior change programs from breastfeeding promotion to immunizations. The literature demonstrates that individuals with stronger common skills are more likely to achieve clinical outcomes related to depression or anxiety, said Singla. People who are perceived to have stronger common skills and interpersonal skills are also more likely to achieve better outcomes. Thus, the model would enable CHWs to address a large proportion of people with depressive and anxiety symptoms, without necessarily targeting these treatment-specific skills. In terms of trainers and supervisors, Singla noted that train-the-trainer models are important and used worldwide because the skills that trainers and supervisors need are quite different than those people who are actually implementing the therapy. Compensation would be commensurate to the skills that CHWs are implementing, she said.
The group discussed how most people are trained in workshops and then carry out supervision, but this is not a scalable approach for training many CHWs over time. These bottlenecks might be addressed through digital platforms or through train-the-implementer, trainer and supervisor model. She noted that with respect to the common and core skills in particular, it is most effective to focus on the existing system and the lay health worker models in each setting. It is important for interventions to be scalable, but equally critical to maintain quality and ensure a personal approach. The group discussed developing curricula for each of the two pathways, which could then be tested to evaluate their foundational hypotheses. Supervision is a core extension of training. However, not everyone who is a good supervisor can be a good trainer or helper because the requisite competencies are different. The group suggested that it might be beneficial to make a separate list of key competencies and characteristics for supervisors and trainers.

4.4.3 Assuring quality of care for common mental disorders

Singla summarized the group’s deliberations about how to assure quality of CMD care in routing health services while still enabling scalability. They generated three key takeaways. Session-by-session symptom measurement would be ideal, in order to monitor an individual’s outcomes and adherence to care. However, this is difficult in practice because it is contingent upon individual’s continuing to access care. Another alternative is to look at data to determine the minimum dose needed for each session to influence clinical outcomes. Based on anecdotal conversations with experts, approximately 6-8 sessions for each individual usually works, but this has yet to be empirically established. This strategy would assess the quality of care CHWs are delivering to individuals who have come in for this minimum number of sessions. The third takeaway was the importance of checklists for both self-monitoring and peer monitoring. Checklists would include items that need to be implemented, such as basic skills, core tasks, or treatment-specific skills. To assure quality,
the group also discussed developing rules for supervision and referral, administering standardized knowledge tests during training and supervision, and carrying out ongoing supervision via a local supervisor. These tasks would be facilitated by leveraging digital platforms and establishing competencies for each skill level.

4.4.4 Role of digital platforms

Finally, they discussed the role of digital platforms in training and supervision. Singla said that telemedicine works and it can be as effective, at least for a certain cadre of people, in targeting things like mild-to-moderate depressive symptoms. Training over Skype is being implemented in some settings, which can be facilitated by a locally based trainer who is there in person with the CHWs. This can be done over several days to train CHWs in health promotion and prevention. Problem Management Plus (PM+) can also be done remotely, she noted, to facilitate training and supervision of these common and treatment-specific skills. However, questions remain about how to integrate these platforms better and what works in practice. Research is needed to determine the effectiveness of any implementation of these additional platforms. Vikram Patel (Harvard Medical School, USA and Sangath, India) added that according to a review of 70 studies carried out around four years prior, there is no relationship between psychotherapy goals. Its multivariable analysis found no association between total contact hours, number sessions or duration of therapy; however, there was one strong factor that predicted clinical outcomes: frequency. That is, individuals who received more sessions in a shorter amount of time had a better effect.

4.4.5 Discussion

During the large-group discussion that followed the working group’s presentation, participants discussed issues related to training, recruitment, and supervision as well as highlighting some ethical issues to consider.

4.4.5.30 Training and recruitment

Patel underscored the benefits of embedding training and supervision into models that have already been utilized in different CHW programs, like the lady health workers in Pakistan or the ASHA workers in India. Rather than reinventing methods of CHW training, he said, it is more productive to map what is already being done and find ways to elevate the tasks and skills using existing methods.

4.4.5.30.11 Competency-based training and common skills toolkit

Basimenye Nhlema (PIH Malawi) emphasized that all health workers should have some level of CMD training in core skills and competencies, irrespective of whether or not they specialize in mental health care. This would also contribute to scaling up programs, she added. Of that, a selected group would then receive onward training in more specialized interventions, of which a smaller group would go on to train in supervision, and so forth. “We tend to go automatically to the treatment and intervention,” she said, “but there is also this other underlying area of CMD scaling which is not always direct intervention.”

Haifa Madi (Ministry of Health, UAE) suggested adding competency-based training in addition to front-line training would address gaps identified in career pathways and quality of care. Singla agreed that there should be competencies assessed at each level of the training and certification processes. A participant highlighted the difficulty in explaining some of these competencies within local contexts. In a roleplay, for instance, it is challenging to explain to someone how to be more empathetic. They are currently exploring the option of using instructional videos to demonstrate the concept of empathy, then asking CHWs to describe how they would strengthen this in their own ways.

Marlene Montoya (Partners In Health/COPE, USA) reported that the Community Outreach and Patient Empowerment (COPE) program requires training in ten
competencies over a full week. Singla called for leveraging existing manuals that already exist for training on these common skills. Giuseppe Raviola (Harvard Medical School and Partners In Health, USA) noted that the COPE program has developed a life-course-focused prevention and common skills tool kit which has integrated mental health. Montoya added that the tool kit includes 30 booklets to facilitate interactions with the community, including pictures, basic dialogue scripts, and Navajo translations of key terms and concepts.

4.4.5.30.12 Self-disclosure and competency assessment in competency-based training
Brandon Kohrt of George Washington University (USA), the Transcultural Psychosocial Organization (Nepal), and the Carter Center (Liberia) remarked upon self-disclosure in a community setting. He questioned how to carry out empathy building, alliance building, and rapport building without some amount of self-disclosure. Evidence indicates that this can be done, and some means of assessing it will be required in order to move toward competency-based training. “If we are going to do competency-based training versus content-based training the difference comes in the supervision,” he said, “…you deliver that first batch, but then throughout the supervision you are titrating and going up or going down.” This allows for presenting evidence to governments that these approaches are feasible and for providing them with instructions about how to implement them.

4.4.5.30.13 Soft skills training and assessment
Rabih El Chammay (Saint Joseph University, Beirut and the National Mental Health Program, Lebanon) remarked that in his experience of training and supervising through mhGAP, the so-called soft skills like empathy and active listening tend to receive less emphasis in training than the treatment-specific skills. More training time should be devoted to developing these interpersonal skills, he said, because the quality of the personal relationship with a patient is the most important factor. Building those competencies are more valuable than rushing to “graduate” CHWs up to the treatment-specific skills too quickly. He suggested that common or core skills should be recharacterized as transitional and cross-cutting, and of equal importance as treatment-specific skills. The extent to which empathy and interpersonal relationships can be taught on the ground is questionable, he said, so perhaps an assessment of those qualities should be weaved into the interview and selection process to ensure the appropriate selection of CHWs who already have these critical qualities. Other types of important core competencies are self-awareness, emotional regulation, and professionalism, he added. “We’re sending people with very limited training to the people’s houses and to their neighbor’s houses. We are asking them to be professional and confidential, but the boundaries can become very blurred and lead to mistakes,” he said. Therefore, it is important to find ways to enhance ethics and professionalism to allow people to straddle the line between being a regular neighbor and a CHW. Conflict resolution is also an important skill, because CHWs may find themselves caught up in interpersonal disputes among those they are serving.

Patel asked if these qualities should be prerequisites for CHWs; El Chammay replied that some of them should be deal breakers—for example, if a person is very judgmental or does not show empathy. Other competencies such as interpersonal skills and emotional regulation might be considered ideal or desirable competencies that may predispose certain people to success in the longer term. Patel wondered about how to best assess these types of competencies in a scalable way, noting that they are not considered during the recruitment process for professional health workers. While these qualities are undoubtedly important, assessing them is very imprecise. Role plays are often planned
to assess interpersonal skills, but in practice, they are not typically used due to the burden on already limited resources. Thus, he suggested focusing on training CHWs in core competencies and accepting that there will be variations in their soft skills, just as there are for doctors and nurses. From his experience at the national experience, Dan Palazuelos (Harvard Medical School and Partners In Health, USA) noted that it may be helpful to involve the community in the selection process—for example, asking them to choose their “natural helpers.” This can avoid preferential treatment for the relatives or associates of specific community leaders who may not be the best fit for the work. Anne Becker (Harvard Medical School, USA) remarked that even if empathy cannot be learned, it can be unlearned. Medical students in the US have been demonstrated to have higher capacity for empathy when they begin than when they end medical school. Training should build in tactics for defending against countervailing forces that undo the training, she added.

4.4.5.30.14 Feasibility of role plays
Kohrt took an optimistic stance by arguing that role plays are feasible and evidence demonstrates the skills that CHWs can acquire and accomplish during 5-, 10-, or 20-day trainings. It is possible to identify those people who are not acquiring the necessary skills and may do more harm than good. All that is needed at the fundamental level is basic empathy and basic respect, he said. Singla agreed that the conversation should focus on taking that evidence and making it scalable, not limited to a trial-based environment, so that role plays are not so cumbersome.

Kohrt said that evidence from non-research-based settings indicates that a trainer’s competencies should include making those assessments as well as integrating simplistic role plays into much of what they are already doing. He offered an example of response after the earthquakes in Haiti: people had to be immediately rolled out in a setting that was not research-based. It was part and parcel to the trainer’s competencies (both in general psychosocial management and mhGAP) that they could carry this out and assess whether the trainings were working. Singla added that digital platforming could help in this regard.

4.4.5.30.15 Career pathways and graduation as incentives
Patel highlighted the importance of creating career pathways that provide opportunities for CHWs to become trainers or supervisors, with corresponding privileges in the form of financial (or other) incentives or prestige. Ultimately, this would be a front-loading investment by the country with a redundancy built into the system. That is, creating a pool of trained workers who will become trainers mitigates the reliance upon expertise, because redundancy engenders scalability.

Patel raised the idea of graduation for CHWs, which could borrow from the rich history of training that comes from other professional disciplines in medicine. Within the medical model, a person begins as a student, then goes through a didactic phase followed by a period of supervised internship. After working for a certain number of years, the person becomes a trainer who loops back and does the supervision of the next batch of students. The inbuilt sustainability of the model is to account for attrition in the first cycle (due to lack of competencies or career changes). Ultimately, the resources are generated by the program itself, which obviates the reliance upon system inputs. However, this requires front-loading the expenditures at the outset to get the system up and running.

4.4.5.30.16 Integrating technology in training
John Naslund (Harvard Medical School, USA) commented that there is, in fact, evidence about technology, but technology should be construed as a gradient with respect to how deeply embedded it is. Technology will inevitably play a role in CHW training, he said: while training may not be carried out exclusively through a digital device, it can be used to support supervision—through text
messaging to connect lay health workers to supervisors, for example. Technology will need to be described in a more nuanced way that takes into account its level of complexity and its integration at different levels of the program, he said.

### 4.4.5.30.17 Resource constraints

Abhijit Nadkarni (London School of Hygiene and Tropical Medicine and Sangath, India) expressed concern about the underrepresentation of countries in which these plans would actually be implemented. He asked about the degree to which the group’s recommendations are desired or aspirational versus aimed at finding a common denominator or bare minimums that could be applied and implemented across settings. Singla replied that this was the objective of identifying common and core skills, based on existing research and what is already being taught.

### 4.4.5.30.18 Mobility and sustainability

Abebay Fekadu (Addis Ababa University, Ethiopia) noted that CHWs are extremely mobile—up to 30%-40% per year—which necessitates training the next generation of workers. Pre-deployment training does not always work and is not scalable or sustainable. Singla said that the group briefly discussed the importance of commitment and sustained motivation as essential characteristics of CHWs. To address this, a model focused on sustainability and scalability might seek out people who can make a definite commitment about time they will serve. Another participant suggested a continuous cycle of training the trainers, perhaps coupled with a higher-level program to train master trainers who then have the opportunity for greater compensation.

### 4.4.5.31 Supervision

Anne Becker departed from this somewhat mechanistic focus to problematize the word “trainer,” suggesting that mentor might be more apt. She conceded that this must be vertical in some ways, but if there is a culture of peer mentors is very important.

### 4.4.5.31.19 Supervision mechanisms to enhance core skills

Siham Sikander (Human Development Research Foundation, Pakistan) recommended building in supervision mechanisms to continuously enhance core skills such as empathetic listening. In the Lady Health Worker program, there is a tendency among workers to be in the “tell” mode and never in the “ask” mode. Although these behaviors cannot be unlearned, there is an opportunity to embed the development of the core competency of empathetic listening into supervision, so that CHWs can learn through submersion rather than trying to teach it over a few days during a training program. Singla clarified that the group considered common skills not only of equal importance to treatment-specific skills, but as the foundation of the training pyramid. Training and supervision should be synchronous, and supervision should be recognized as a core extension of the training process.

### 4.4.5.32 Ethical concerns

#### 4.4.5.32.21 Ethics of protecting communities

Gugu Gigaba (University of KwaZulu-Natal/Mental Health Integration Programme, South
Africa) highlighted the ethical concerns around handling the situation of CHWs who do not achieve competencies, as it relates to protecting the public. This is linked to issues around who governs the CHWs and what should happen if CHWs cause any harm to people under their remit. She questioned whether they should be fired and if not, what measures could be put into place to protect communities. Singla concurred about the importance of considering ethics in discussions of essential CHW characteristics.

4.4.5.32.22 Ethics of selection and exclusion

Inka Weissbecker (International Medical Corps, United States) broached the topic of ethics around selection and exclusion of CHWs. Building onto existing systems is always the goal, but those systems vary widely: some settings have good systems in place with CHWs that function well, others have existing systems with CHWs but they may be overwhelmed, and other settings have no CHWs in existing systems at all. She questioned the amount of control implementers have over the selection of CHWs in practice. For example, she asked whether CHWs should be excluded from training just because they do not meet some element of the selection criteria (e.g., not having a criminal record) or because they are not willing to work with people who have mental illnesses. Similar concerns apply to selecting trainers and supervisors within the system versus outside the system—that is, whether they are people from implementing NGOs or they are already part of the existing health system. She noted that existing CHWs typically report to existing staff, who may not have been trained in mental health either. Singla responded that the group discussed an alternate hierarchy for CHWs who report to doctors or nurses who might not have the skills that are being taught during the CHW trainings. One idea was to collaborate with those supervisors to inform them about what the CHWs are being taught, or even to invite those supervisors to the trainings (although the latter may be less feasible). Ideally, everyone would be trained in the common skills and core skills and with the view to eventually building a cadre of trainers and supervisors as the process continues.

Alex Riley, science writer, commented upon the deal-breaker of a criminal record. He met a CHW in New York with a decade of experience who is the only peer supervisor in the New York State Health Department. She has a criminal record of 25 years and that is related to her lived experience. She would be excluded based on the criteria being discussed, despite being an exemplary CHW. He suggested providing more nuance and flexibility with respect to the criminal record criteria. Singla agreed, suggesting that that criterion should be eliminated. “We wouldn’t want individuals who are so competent to be taken away from the potential CHW role through which they could contribute to the system,” she said. These essential characteristics are context-specific and require appropriate flexibility. Raviola referred the group to a recent paper on prison mental health that explores the potential for prisoners to be CHWs.

4.4.5.32.23 Balancing quality assurance with burden of tasks

A participant noted that assuring quality of the services being provided needs to be balanced with the number of tasks that CHWs are assigned. Raviola underscored the importance of considering the mental health and wellbeing of CHWs.

4.5 WORKING GROUP ON COMMUNITY HEALTH WORKER RECRUITMENT, TRAINING, AND SUPERVISION: SECOND SESSION

Daisy Singla reported back from the second session of the working group on CHW recruitment, training, and supervision. She reiterated that the group envisioned at least two types of training. One focuses on training CHWs on basic common skills, such as basic
counseling skills, as well as on tasks including risk assessment, screening, and case finding. The common skills are those thought to be beneficial to all CHWs, regardless of what they are implementing from mental health to breastfeeding promotion to immunizations and so forth. The second type focuses on training in basic psychological treatment packages and service delivery, which expands upon the idea of a three-tiered structure. They also discussed the key criteria that CHWs would need to meet in order to be eligible for both types of training.

The group shaped its second discussion based upon the discussion after the first session, particularly in terms of safety and referral. The group adapted the pyramid of training and supervision to reflect the feedback, situating core tasks and common skills at the foundation (see Figure 22).

Figure 22. Training and supervising community health workers in a scalable way

![Figure 22](image)

Source: Harvard Medical School Center for Global Health Delivery-Dubai, Working group on community health worker recruitment, training, and supervision 2018a.

4.5.1 Dos and don’ts for recruiting, training, and supervising community health workers

Singla focused on a set of “dos” and don’ts” related to the idea of training CHWs on basic common skills and core tasks. She noted that it aligns with what working group on CHW tasks and roles suggested about the foundation of core tasks and common skills focusing on health promotion, identification, risk assessment, and referral. These dos and don’ts were categorized as must-haves (essentials), nice-to-haves (desirables), and don’ts (see Table 41).
Table 8. Common skills and core tasks in recruitment, training, and supervision

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<thead>
<tr>
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<th>Must-haves (essential)</th>
<th>Nice-to-haves (desirable)</th>
<th>Don’ts</th>
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<tbody>
<tr>
<td>Recruitment</td>
<td>Characteristics:</td>
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<td></td>
<td>• Language proficiency</td>
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<td>• Commitment</td>
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<td>• Reputation in community</td>
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<td>• Community engagement</td>
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<tr>
<td>Training</td>
<td>Curriculum:</td>
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<td></td>
<td>• Structured</td>
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<td>• Manualized</td>
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<td>• 1-2 day training</td>
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<td>• Participatory and active learning</td>
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<td>• Boundaries</td>
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<td>• Specialized populations</td>
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<td>Supervision (assuring quality)</td>
<td>Competency:</td>
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<tr>
<td></td>
<td>• Trainer feedback</td>
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<td></td>
<td>• Peer supervision</td>
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<td></td>
<td>• Pairing weaker trainers with strong trainers</td>
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<td></td>
<td>Competency:</td>
<td>Self-care module</td>
<td>Theory-based discussion (including powerpoints)</td>
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<td></td>
<td>• Multiple choice</td>
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<td></td>
<td>• Role plays</td>
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Source: Harvard Medical School Center for Global Health Delivery-Dubai, Working group on community health worker recruitment, training, and supervision 2018a.

4.5.1.33 Recruitment

In terms of recruitment, Singla said that local language proficiency, commitment, reputation with locals, and ability to engage with communities are all non-negotiable characteristics for CHWs. Desirable characteristics are context-specific, and might include education level, interpersonal skills, and physical and emotional stability. She noted that the group had eliminated the criteria for a lack of criminal record. Individuals would not be eligible to be CHWs if they are not from the community they serve, do not speak the language, or are active abusers.

4.5.1.34 Training

The group suggested that essentials for training include a structured, manualized curriculum to train CHWs on common skills and core tasks, which is brief enough to be carried out over 1-2 days and is pedagogically centered in participatory and active learning. CHWs should also be trained in how to maintain boundaries without offending the communities they are serving. The curriculum should also be modifiable for specialized populations, such as children or adolescents. A self-care module would be desirable if time allowed, although she noted that it could be considered a must-have (that is, people need to attend to themselves if they are going to attend to others). The group agreed that theory-based, didactic discussions should be avoided in CHW training. Instead, individuals should be given an opportunity to participate and practice the skills they are learning.
4.5.1.35 Supervision
Supervision in the common skills and core task training should focus on competency, which can be measured in different ways. Trainer feedback is probably the most scalable method, despite its subjectivity, because the trainer would be considered an expert. Peer supervision was also deemed essential to assure quality in a scalable way. This could involve pairing weaker implementers with stronger implementers. They did not include multiple choice exams or role plays as must-haves in competency assessment—although it is beneficial—because they are difficult to implement in a scalable way.

4.5.1.36 Identification and referral
Singla noted that identification and referral are core tasks in making sure that individuals do not fall through the cracks. The group felt strongly that CHWs should not be trained in identification or case detection if there is no referral system in place, whether to a mental health specialist or a primary care provider who has been trained or is willing to be trained. They were not able to discuss recommendations for psychological treatments due to time constraints. However, for a system to transition from core tasks to the provision of psychological treatments—regardless of what is being implemented—linkages and referral systems are essential to ensure the safety of severe patients, as well as a supply chain of medication and people who are available to supervise or be trained to do so.

4.5.1.37 Checklists for situational analysis
Laura Murray noted that checklists would be used before the core tasks and common skills in the pyramid. The group brainstormed specific questions to provide implementers with a guide as to where they are located in the pyramid. They discussed the need to identify redundancies and gaps through a simple type of situational analysis, pared down to identify very specific questions:

- Who are the people being trained, if any are available?
- Is supervision available and if so, who is it done by?
- Are there treatments available and if so, what do those look like?
- Who are the mental health professionals available in the setting?

It is important to be very careful to ensure that there is treatment available as soon as CHWs are trained to start identifying cases and making referrals, Murray warned. Doing so without treatment available creates huge ethical problems, which is why the checklist is so critical as a starting point.

4.5.2 Discussion
4.5.2.38 Suggestions for training design
Gloria Pedersen (George Washington University) noted that there are common skills universal for all CHWs delivering therapy. To improve efficiency, she suggested creating a scaffold to teach those skills—as a sort of psychological first aid—within the training for the CHWs’ core tasks. A participant suggested that levels of training should be linked to career advancement, salary, and/or licensing in order to incentivize further training and facilitate scale up. Another participant suggested leveraging technology and digital platforms in training CHWs on psychological treatments, even if it is less useful in training for core and soft skills.

Kohrt recommended against placing time parameters on trainings, because activities and responsibilities are setting-specific and not universal. He suggested using case studies to illustrate how different sites accomplish training of different durations in various contexts. Training and supervising on common skills needs to be quick and cheap to allow for scalability, said Murray, so the group focused on training large numbers of CHWs.

El Chammay contended that to promote treatment, CHW training should be designed
primarily to improve community engagement, facilitate interaction with stakeholders, and reduce stigma. He asked whether the communities should be engaged in the selection process and suggested that more guidance on the recruitment process would be helpful in settings that have the opportunity to recruit people.

In the context of social inclusion, Patel remarked that the core tasks might include CHW interventions for engaging in social determinants. In his experiences with front-line workers, they already have an established role in dealing with domestic partnerships. He suggested that connecting domestic violence to mental health problems could be a potential avenue for training. Singla replied that this might fit into components of risk assessment that could be reflected in the core tasks for the sake of comprehensiveness in addition to scalability.

4.5.2.39 Assessment of selection criteria
Regarding recruitment of all CHWs, Patel remarked that selection is already a fait accompli at the first level. Depression or CMD programs must work with who is there already, rather than selecting new people. The selection issue becomes more relevant in the second stage (psychological treatment).

It may be difficult to measure some of the selection criteria the group proposed for CHWs, said Abhijit Nadkarni. He asked how someone’s reputation in the community would be measured and if there is evidence showing that people with that characteristic are better CHWs. He suggested a broader focus on treatment, supervision, and putting systems in place to improve safety in the delivery of care by CHWs. He cautioned against waiting to strengthen those elements until a larger ecosystem is in place.

4.5.2.40 Regulation, certification, licensing, and accreditation
From an accreditation perspective, Farah Aqel (Dubai Health Authority, UAE) stressed that there should be policies and procedures in place across the board in order to establish generalizable, replicable, and organized processes. A participant suggested explicitly identifying the regulating body for CHWs in the guidelines, as is the case for other specialties and disciplines. WHO recommends 15 principles for CHWs that should be forefronted in this work, said Kohrt. It lays out career pathways, competency-based trainings, procedures, and expectations that could be further specified for mental health, with the relevant program-specific regulatory body put in place (see Box 41).69
Box 8. WHO community health worker guidelines

Brandon Kohrt provided an overview of World Health Organizations guidelines for community health workers:

- Selection criteria
- Duration of pre-service training
- Competencies (including personal safety, promotion/prevention, interpersonal skills, integration, and psychosocial support)
- Modalities of training (practical)
- Competency-based certification
- Supportive supervision
- Remuneration, not incentive-based
- Career ladder
- Contracting agreements
- Target population size (constant and variable)
- Data collection and use
- Types of community health workers (general and specific)
- Community engagement
- Mobilization of community resources
- Supplies

A participant commented that in Dubai, they are competing with other training bodies who are not doing appropriately certifiable or sufficient training for their providers. People tend to gravitate toward these providers because they offer very abbreviated training programs in untested approaches, rather than attending more legitimate training mental health care. He was concerned that this is undercutting the quality of the mental health workforce in the country. Implementing CHW training programs on core tasks and common skills will require appropriate certification, said Singla. The concept of certification is central to successful training and to mitigating competition from non-validated trainers. Kohrt suggested that the 15 WHO recommendations for any CHW program could serve as competency-based certification. Aqel cautioned that the public is not concerned about the type of certification they receive, but merely that they get certification at all, regardless of its validity. The approach being taken in Dubai to address this is through monitoring and licensing of mental health workers. People need to be protected by creating clear guidelines, licensing, and regulation of training programs for CHWs. Pedersen agreed, citing an example from South Africa in which patients with severe mental illnesses were discharged inappropriately, leading to more than 100 deaths. The consequent litigation process led to a huge government payout and as a result, the Department of Health is very concerned about any certification that does not include both licensing and regulation.
4.5.2.41 Delivery of psychological treatments without referral systems in place

Patel reflected on the contention that psychological treatments should not be delivered unless there is a referral system in place. On one level, he understands the rationale that we should only deliver treatments when specialized personnel are available, but he finds it counterintuitive on another level. Perhaps the opposite rationale should hold, he suggested: to deliver the treatments where there are no specialized personnel, because there is no other option in those contexts. “Why would we deny an effective treatment in the absence of any alternative,” he remarked, “as opposed to providing it when there is an alternative.”

The former approach also runs counter to the transition in the field toward self-treatment and treatment through digital platforms, he added. It is difficult to square this move toward low-intensity, self-delivered psychological treatment with the edict that CHWs who have been trained with these common skills should not deliver simple, evidence-based psychological treatments because there is no superstructure of mental health therapy in place. This is a critical issue, because recommending that the delivery of psychological therapies be contingent upon such a superstructure effectively declares that existing evidence around psychological therapies will not work in most parts of the world.

Kohrt clarified some of the staging suggested by his group, framed within increasing levels of psychiatric services. Stage 0 is difficult to find, because it simply serves to draw the attention of planners. The transition from Stage 0 to Stage 1 involves identifying the closest referral in a psychiatric emergency situation, which could potentially be days of travel away. Thus in Stage 1, prior to psychological interventions there are basic competencies already in place for handling emergencies that are tailored to the specific setting (which includes family support and local resources, for example).

The transition from Stage 1 to Stage 2 centers on a safe working environment for CHWs, which protects them and enables them to deliver their work effectively. The transition from Stage 2 to 3 involves putting CHW supervision structures into place, be it peer supervision or some other system within which CHWs are not delivering treatment individually. The spectrum is an incremental process which recharacterizes the stages for appropriate activities of community mental health workers: identify a referral source, identify a contact; protect the CHWs so they can effectively deliver interventions to support people; then provide explicit supervision as available.

Singla noted that the group is not advocating for a complex referral system, but about embedding training at each level to ensure safety of CHWs and patients in the event of an emergency. Kohrt emphasized that they are also talking about the bare minimum when it comes to referrals within the spectrum when designing programs. For example, training CHWs how to handle a case of postpartum mania or psychosis may simply be education on the local availability of medications or how to travel to a location for psychiatric referral. This type of planning needs to be practical and flexible, and tailored to a broader audience than just clinicians. It does not impede pre-existing trials or post-trial scale up of these activities, he added.

Alison Schafer (World Health Organization, Geneva) explained that part of the group’s analysis included the need to meet the demand. In some cases, there may not be enough psychological treatments as needed. Patel suggested framing the recommendation by stating that in the absence of a referral system, a referral system should be put into place, rather than advising that nothing be done at all. It is dangerous to promote the message that ignorance of a person’s condition is better than knowledge, he warned. In HIV, the emphasis was initially on knowing that a person was HIV-positive, because knowing was in and of itself a helpful piece of information for that person or family, even when there was no treatment available.
4.5.2.42 Guidelines for programmatic judgment by local stakeholders

Raviola suggested developing a process of programmatic judgment in selecting interventions and determining how long trainings should last to facilitate decision making within the context of a specific program. Technical advisement and consultation may be very different when local teams may have already made sets of decisions and determinations, he noted, or when local teams do not have prior knowledge of available treatments. He asked if there is an existing literature base for developing guidance to support internal stakeholders in making decisions. At PIH sites, for example, the presumption that such decisions are made by outsiders is often used to try and invalidate the work being done. Kohrt noted that the first recommendation of World Psychiatric Association’s community-based health care is to involve stakeholders in the program design and priority setting. Murray said that implementation science has elucidated certain steps that can help frame, support, and scale organizational and community interventions as well as psychological ones. She suggested creating a basic package for organizational interventions to set forth what is required to implement a mental health program. Verdeli commented that programs are dynamic and must be able to self-correct as they evolve.

4.5.2.43 Stakeholder engagement and social inclusion

A participant merged the concepts of self-directed correction with stakeholder engagement and the additional goal of social inclusion. She observed that in the schematic from conception to development to execution and follow up, stakeholders need to be engaged to determine whether the process has been successful and to better understand how to improve it through the self-improvement model. However, the stakeholders and beneficiaries engaged will speak a different language than implementers: the language of quality of life, social relationships and engagement, social exclusion, and social cohesion. She suggested adding into the pyramid notions of functionality in quality of life and wellbeing, because “…as soon as you talk about people’s lives, you must encapsulate the whole person and their whole communities.” For example, CHWs who are particularly adept at improving functionality (e.g., through occupational therapy or rehab-related skill sets) might be added to the pyramid between the supervisor and psychological treatment levels. The model should strike a balance between health and functionality, she said, which can empower individuals to reach their potential in the larger systems model within which their community relationships are integrated. Singla replied that it might be part of the recruitment criteria for CHWs to ascend the pyramid of certification to psychological treatments. Kohrt proposed inclusion in Stage 2, when there is protected time to deliver those services that can immediately be effective.
5 Systems and strategies for integration

5.1 INTRODUCTION

Chapter 5 provides a summary of the workshop’s output related to systems and strategies for integration. It includes a review presentation on systems-level strategies for community health worker (CHW) integration into routine primary healthcare platforms, reflections from a panel of expert implementers, report outs from the working group’s two sessions, and the following large-group discussions.

The working group’s remit was to define the strategies for health care systems to support, enable, and sustain the integration of CHW interventions for common mental disorders (CMD). They considered the barriers to the integration of CHW interventions for CMD in routine health care, with particular respect to contexts where primary care is weak or fragmented, as well as potential ways to address those barriers and how digital technologies might enable integration of these interventions. They also discussed how to estimate the per capita number of CHW for integrating CMD care, assuming generic CHW are providing CMD care alongside their other duties, as well as the referral pathways and enablers needed to ensure ‘stepping up’ and ‘stepping down’ according to patient needs. The group explored ways to ensure that mental health is not integrated as a vertical service or seen as an add-on service; potential threats to sustaining CHW care for CMDs were also discussed. Because systems can be inherently resistant to change, they deliberated upon strategies for creating “buy-in” when attempting to implement these novel models of care delivery.

5.2 SYSTEMS-LEVEL STRATEGIES FOR COMMUNITY HEALTH WORKER INTEGRATION INTO ROUTINE PRIMARY HEALTH CARE PLATFORMS: REVIEW PRESENTATION

A review presentation on systems-level strategies for CHW integration into routine primary healthcare platforms was provided by Inge Petersen, director of the Centre for Rural Health (CRH) in the College of Health Sciences at the University of KwaZulu-Natal, South Africa and visiting professor in the Department of Health Service and Population Research in the Institute of Psychiatry, Psychology and Neuroscience at Kings College, London. She opened her review presentation with the caveat that there is a dearth of systems-level strategy evidence to date, although that is being addressed. However, she was able to draw from the work of PRIME70 and EMERALD initiatives, both of which have been looking at the systems-level strengthening required to enable integration. She also discussed a mental health integration program ongoing in South Africa, in collaboration with the University of Washington.

The rationale for integrating CHW interventions into primary care platforms, said Petersen, is that health care practices and services need to be directed toward and organized around the needs of people who use and are served by health care service providers. To work toward this aim of people-centered care at the community level, CHW interventions need to be linked with the different levels of care in order to step up or step down that care. These interventions might take the form of a mixed model of integrated delivery by CHWs and mental health specialists, she suggested. She explained that CMDs are situated

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70 For more information about the PRIME initiative, see https://www.centreforglobalmentalhealth.org/prime-programme-for-improving-mental-health-care (accessed September 7, 2018).
along a spectrum: wellness, mild, moderate severe, and severe. Treating CMDs requires a continuum of care across all levels, from community to specialist care, with the ability to step up and step down care according to the level of need. Within this integrated model of people-centered care, the person is viewed holistically (see Figure 23).

**Figure 23. Principles of comprehensive care**

5.2.1 Incorporating an integrated package

Petersen outlined the key health systems building blocks involved in incorporating an integrated package of care: people; leadership and governance; the health workforce; medical products, vaccines, and technologies; information systems; service delivery; and financing.

At the center of the system are **people**: empowered activated, caregivers and users for self-care and support.

**Leadership and governance** need to include policy and legislative frameworks that enable

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71 Patel 2017

integration. She noted that progress on this front has been made in low- and middle-income countries. On a policy level, mental health must be a constituent of the scope of practice for CHWs. This has been a challenge in South Africa, where they work with lay HIV counselors whose scope does not include mental health.

In the context of the **health workforce**, CHWs should be part of primary healthcare staffing structure and not just seen as an add-on. Training, certification, and career pathways must be in place. Additional regulation and scope of practice issues also need to be addressed, both for the protection of CHW as well as the people they are serving.\(^\text{73}\) A critical mass of mental health specialists is needed to provide CHW supervision and support,\(^\text{74}\) which is a prerequisite that requires budgetary support. Further needs include revised core competencies, job descriptions, and pre/in-service training for task sharing for mental health specialists.\(^\text{75}\) In South Africa, a panel is looking at revising core competencies of all health care providers, which will be presented to government at the end of the year.

**Medical products, vaccines, and technologies** also need to be strengthened, with psychotropic medicine part of Essential Drug List (EDL), along with a supply chain management and dispensing system that supports chronic care. Guidelines and manuals should be available.

**Information systems** require sufficient feasible indicators to monitor and evaluate CHW tasks relating to mental health, implemented with a continuous quality improvement framework.

In the area of **service delivery**, a shift is needed from acute care models to acute and chronic care models coupled with a revitalization of community-oriented primary healthcare, in which CHW programs are linked to facilities. For example, South Africa has adopted this model of re-engineering primary healthcare using CHW ward-based teams attached to each facility, enabling linkage between community and facility. The collaborative care model\(^\text{76}\) has been shown to be the most effective model for the delivery of integrated mental healthcare. It requires service coordination and team care; task sharing; case management; treatment to target; and collaboration with community supports.

**Financing** needs include budgeting for CHW posts as well as for supervisors and mentors.\(^\text{77}\)

### 5.2.2 Rural health model of collaborative mental health care

Petersen provided an example from South Africa of how the PRIME model has been implemented by a district into their district mental healthcare plan (see Figure 52). CHW teams at the community are linked to facilities. Roles and responsibilities are allocated to different people, rather than overburdening CHWs with all of the tasks, which is a significant problem in many settings. In this model, the CHWs do awareness raising, screening, and referrals. Facility-based lay counselors also carry out awareness raising, screening, referrals, and basic psychosocial support through evidence-based psychosocial counseling for CMDs. Certified nurse practitioners carry out screening, assessment, diagnosis, basic psychosocial support, and continuing care. Medical officers can diagnose patients and initiate psychotropic medication as needed. In the community, social workers and auxiliary social workers carry out rehabilitation and reintegration tasks for more severe mental disorders. At the district level are psychiatrists, psychologists, and various other specialists who provide direct care, training, supervision, quality assurance, and technical support. At the management level, a mental health coordinator provides inter-program and intersectoral coordination.

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73 Palazuelos et al 2018  
74 Barnett et al 2018  
75 Institute of Medicine 2013  
76 Patel 2017; Patel et al 2013  
77 Palazuelos et al 2018
monitoring and evaluation, technical support, and quality assurance. She conceded that in this middle-income setting in South Africa, the integration of the model was more elaborate than it would be in settings that are more resource-constrained.

Figure 24. Rural mental health model: collaborative mental health care

5.2.3 Strategies for integration

Petersen described some potential strategies for integration, including systems-wide evidence-based technical support packages, engagement methods, and using continuous quality improvement as a vehicle for change.

5.2.3.44 Systems-wide evidence-based technical support packages

Petersen used the example of Mental Health Integration Programme (MhINT) to illustrate a systems-wide evidence-based technical support package, which is one strategy for integration. It is critical to have a structure like this in place when working with a department of health, she noted. The focus of MhINT is on integrating mental health into routine primary care systems through working with departments of health instead of with NGO or parallel services offered within countries. MhINT is a three-phase program that loosely follows the WHO operational plan. The first phase is an intensive planning phase, which involves engaging with all levels of the system (i.e., national department of health, provincial government, district, and sub-district) to carry out a situational analysis, which is then integrated into a district mental health care plan. The second phase, preparation, involves capacity building with clinical psychologists, doctors, registered psychological counselors, lay counselors, and facility managers. This capacity building promotes integration. The third phase is to provide support through supervision, mentoring, reporting, and
emotional support. The latter is essential for CHWs who are providing psychosocial interventions due to the emotional labor required; she noted that CHWs experience similar problems in their communities. The three phases are introduced within a continuous quality improvement framework as a vehicle for implementation.

5.2.3.45 Engagement

Engagement is another strategy for integration, but it is a challenging process. Petersen said that it is crucial to garner support from government and community structures at the national to local levels through MOUs and negotiations. She called for leveraging the role that integration of mental healthcare can play in assisting with existing priorities; unfortunately, mental health is not a priority right now, even though the relationship between mental health and HIV is clear. In South Africa, an over-focus on HIV has created problems with quality of care, she added.78

In terms of staffing, “we have to work with what we’ve got if we want integrated, sustained systems...but sometimes they might not be the right people.” However, she suggested leveraging existing cadres of workers to promote integrated care wherever possible. This should utilize existing training and management platforms to avoid introducing parallel systems, she added. In South Africa, they work with existing regional training centers to train the trainers, with the department of health seen as the provider.79

This is important because there are dangers in being seen as an NGO providing the service. She warned that donor-funded development support partners may have their own agendas and in providing a parallel service, the department of health becomes dependent upon them. When the time comes for the Department of Health and others sectors to integrate and provide technical support for the integrated care, there is often resistance to changing a system within which providers have become familiar.

5.2.3.46 Continuous quality improvement as a vehicle for change management

The third strategy Petersen explored is continuous quality improvement (CQI) as a vehicle for change management. There is much work to be done transforming the health system to be more enabling of integrated care and task sharing in the face of substantial resistance to change. On the “hardware” side, CQI is a process that identifies deficits and tests changes needed to address identified implementation problems in collaboration with service managers, providers, and communities.80 It is an empowering approach that can drive small policy changes, which can catalyze systemwide changes at the policy level, she said. On the “software” side, CQI empowers by changing the culture and building the will to implement required changes, in that the people delivering and receiving the services are identifying the problems and working together to find solutions.81 The approach also promotes teamwork essential for collaborative care and task sharing, she added.

5.3 PANEL: IMPLEMENTERS’ REFLECTIONS ON SYSTEMS AND STRATEGIES FOR INTEGRATION

Inge Petersen moderated the panel on systems and strategies for integration. Expert implementers with experience on the ground were asked to reflect on possible innovative mechanisms to support CHWs in providing psychosocial interventions, particularly in settings where there is a scarcity of human resources necessary for supervision and support of CHWs. They also considered how to address the problem of limited referral pathways for people needing stepped-up care—for example, through a phased approach to integration that focuses efforts initially.

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78 Petersen 2018
79 Ibid.
80 Ibid.
81 Ibid.
on strengthening the primary care system to provide the necessary referral pathways for stepped-up care where necessary, before embarking on community level screening, and so forth. Panelists were also asked about ways to ensure that mental health is not integrated as a vertical service or seen as an add-on service.

The panelists included:

- Gugu Gigaba (University of KwaZulu-Natal/ Mental Health Integration Project, South Africa)
- Rahul Shidhaye (Public Health Foundation of India, New Delhi and Sangath, India)
- Inka Weissbecker (International Medical Corps, United States)
- Subandi Deran (Gadjah Mada University, Indonesia)
- Hildegarde Mukasakindi (University of Global Health Equity/Partners In Health/ InshutiMu Buzima, Rwanda)
- Basimenye Nhlema (Partners In Health/ Abwenzi Pa Za Umoyo, Malawi)

Gugu Gigaba is a clinical psychologist whose research interests have predominantly been in issues around identity, African psychology, sexuality, youth risk, sexual behaviors, and community psychology. She is currently the Programme Manager for the Mental Health Integration Programme (MhINT) at the Centre for Rural Health at the University of KwaZulu-Natal. She shared her experience in leading the team driving the integration of mental health services.

Gigaba explained that their chosen vehicle for implementing an integrated mental health care service in primary healthcare is CQI, a data driven and system-focused methodology. CQI promotes collaboration and utilizing this approach positions technical support partners as willing to listen to the system they are attempting to assist. The CQI methodology provides simple ways to understand the science of improvement as well as accessible tools for achieving sustainable change. She explained that the quality improvement process has to be multilevel, taking into consideration the interventions being carried out at each level. The initial step is “hearing them out”; in this case, gaining an understanding of what prohibits the provision of effective mental health service from the perspective of the different levels of the healthcare system. At the very top level, the national department of health provides guidelines and policies which they expect informs healthcare service provision from the provincial level, to district level, primary health care level, and all the way through to the community level. Therefore part of diagnosing the problem in executing government policy, is exploring and becoming aware of the contextual factors faced by each of the facilities that can impact upon achieving an integrated mental healthcare service. As part of their programme, Gigaba explained they employ a collaborative process of identifying resources that can be activated to make new mental health services possible using a task-sharing approach at the various levels of the system. With CQI, the use of data is critical and as technical support partners they can present data in a way that is supportive as opposed to punitive. The data is rather used like a mirror to assist the health system to be aware of where they are stuck and therefore support them in setting context-specific, realistic, and measurable targets that they can achieve. They also support the system in developing change ideas that can be implemented in short PDSA cycles so that successful change ideas can be adopted as part of standard practice and ultimately possibly contribute to policy change. In that sense, CQI is a powerful and empowering approach. She noted that the intervention should be positioned as a solution to the problem that providers have identified themselves using data.

Rahul Shidhaye is a public health psychiatrist. His research work is mainly in the areas of integration of mental health in primary care, mental health systems strengthening and implementation science. He is principal
investigator for the ESSENCE (Enabling translation of Science to Service to Enhance Depression Care) project and is the country principal investigator for various research program consortiums. Shidhaye highlighted five key questions gleaned from his own experiences:

- Can care processes be standardized, which can then serve as a basis for process and quality improvement?
- Mental health is a priority for communities as well as care providers: should messages be repackaged?
- Do people work beyond monetary incentives, or is there something more to it?
- Just like continuum of care, can we also consider the continuum of support (includes both clinical and implementation support)?
- Interventions and service providers are often like oil and water: can CHWs act as emulsifiers to bring communities closer to providers and interventions?

**Inka Weissbecker** is the Senior Global Mental Health and Psychosocial Support (MHPSS) Advisor for International Medical Corps (IMC). In this role, she provides remote and on-site technical oversight and support to project countries in the areas of assessment, program design, project implementation, and evaluation of MHPSS programs in over 20 countries. She explained that IMC works in around the world in countries affected by conflict, crises, and natural disasters. The context of their work gives rise to many different challenges that are also relevant to CHWs. For example, the people in these affected countries often have very high mental health needs. WHO estimates that CMDs affect 10%-20% of people in humanitarian settings; other people in these settings are experiencing psychological distress and need support. In addition to a high level of mental health needs, these settings also face challenges in their healthcare systems, such as high turnover of staff, highly mobile populations (including staff), and security challenges. These challenges impact the way that work is carried out, as well as the sustainability of that work.

Weissbecker said that IMC, in collaboration with partners including WHO, has developed a Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings that was launched as part of the Mental Health Innovation Network. The toolkit provides a framework for strengthening the process of integrating mental health into primary health care, which encompasses three key steps and three crosscutting components. The first step is assessment and situational analysis to plan for integration. This includes assessing the country, context, existing mental health policies and guidelines, human resources, the availability and location of CHWs, and CHW tasks and competencies. The second step focuses on training and supervision to build the capacity of general healthcare workers, which involves adapting and developing training programs—including the WHO mhGAP intervention guidelines—for local health cadres. The third step is to strengthen mental health services and systems. This includes consideration of how to strengthen the system at the facility level; this is also informed by the initial situational analysis of staff capacity, the availability of psychotropic medications, referral pathways, and coordination among members of the health team. Cross-cutting components include: monitoring, evaluation, accountability, and learning; advocacy, coordination, and networking by engaging with stakeholders at all levels; and planning for sustainability from the outset, which is crucial even in humanitarian settings. Weissbecker noted that the Toolkit provides tools, resources, and case studies (available online) to support all of the steps and cross-cutting components.

**Subandi Deran** is a professor of clinical psychology at Faculty of Psychology, Gadjah Mada University. Inka Weissbecker

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Mada University. His research interests are in the area of socio cultural and spiritual aspects of mental health, early psychosis and mental health systems. He works on strengthening mental health services in the primary health center in Yogyakarta, Indonesia. The overall goal of this program is to provide a better mental health services in the primary health center setting, despite the problem of treatment gaps in Indonesia.

Deran shared experiences from integrating CHWs in Indonesia. They do not use the term mental health worker in the country—they use the terms mental health cadre, because it is more positively nuanced and empowering. It can make them more proactive and take more initiative. The mental health cadres tend to be older, in their 50s or 60s, and work on an unpaid voluntary basis under the auspices of the village government authorities, not the primary care system. Within the village mental health program, CHWs are integrated with professionals in primary healthcare facilities. They have primary health nurses, community mental health nurses, teachers, and religious leaders involved in the program, as well as a school-based program. Jakarta has resources including psychologists, CHWs, and psychiatric residents. The Ministry of Health is strongly engaged, and they also have a school-based program. Deran explained that standard operating procedures are crucial, as well as strengthening the village mental health program, which was initially implemented after the tsunami but is now integrated into the system with a scope beyond emergencies.

Hildegarde Mukasakindi is associate director of the mental health at IMB; her main responsibility is working with the Ministry of Health in Rwanda to develop and integrate high-quality, evidenced-based, culturally sound, patient- and family-centered, community-based mental health systems that are integrated into the public sector primary care systems in Rwanda. She discussed the mental health program in Rwanda, where Partners In Health (PIH) is working with the Ministry of Health to strengthen the healthcare system, with particular focus on integrating mental health. She explained the system of care in Rwanda. After the 1994 genocide, the government made mental health a priority. They have a referral hospital, provincial hospitals, district health posts, and CHWs. The PIH model is focusing on integrating care at the district to village level, with specific focus on the links between post-traumatic stress disorder and depression. In the standard of care, PIH and the government work together to screen for and diagnose mental health issues. At the district level, there are psychologists at the district health centers. Task sharing with neighbors and village leaders supports the overburdened CHWs. There is mentorship, training, and supervision for CHWs, as well as coordination between health centers and district hospitals. She recently met with government leaders and told them that at the community level, CHWs are overburdened and only have one day per week to do mental health tasks, which is not enough. When Mukasakindi asked them about integration, they said that at the system level, integration is a process and we have achieved integration. However, at the patient-care level, it is challenging because they are not able to screen all patients who visit facilities, especially for depression, which often has symptoms that overlap with physical health conditions. At the health center level, PHQ-9 is their only screening tool.

Basimenye Nhlema is the Director of Community Health at Partners In Health in Malawi. In this capacity, she leads and manages the CHW program, the Community Programs team, and the Program on Social and Economic Rights (POSER), interdisciplinary teams focusing on community health in a rural and impoverished population. The CHW program manages nearly 1000 CHWs who focus on education and health screening at the household level; the community programs team runs an innovative integrated screening program for chronic conditions in remote areas; and the POSER team provides support to patients’ basic social and economic needs. Nhlema shared experiences with PIH in Malawi, which
works in partnership with the public health facilities. The cascade of care sits at the home, community, and health facility levels as well as at the hospital level. Currently, they have 1,200 CHW, all of whom are attached to the 14 facilities in the district. They work under government-recruited CHWs who are called health surveillance assistants. Extra CHWs hired by PIH work as foot soldiers to support and alleviate the burden on the workers hired by the state. She explained that mental health is one of the eight conditions that CHWs address at the household level. CHWs are attached to specific homes; in the homes they visit, they are responsible for accompanying patients to clinics and supporting adherence, as well as providing health education and referring patients with side effects to facilities. At the community level, there is a screening program whereby teams from health centers and hospitals come to the community to screen for a number of conditions, mainly noncommunicable diseases. Mental health is not yet included, she said, but some day it may be part of the package.

At the primary care level, CHWs work directly with the government-recruited health surveillance assistants, who are mostly positioned at facility level. Nhlema said that the aim is to directly link CHWs to the facility-based teams to ensure that CHWs have what they need. For example, coordination of care between CHWs and the government-employed workers takes place during case management meetings. The government-recruited CHW meets weekly with a site supervisor, who is linked with the CHW, to discuss new patient enrolment in tuberculosis and malnutrition programs, and what the patient needs (follow up, enrolment in hospital, etc.). Once the site supervisor has this information, he/she passes it on to the nongovernmental CHWs. Moving forward, they are looking at having a similar strategy for mental health. For example, this might involve having someone skilled at the facility level who can act as a link between mental health specialists and CHWs. Currently, the information that CHWs have and the services they provide are very basic. There is a huge gap between homes and specialist care that CHWs may help to address, she added.

Abebaw Fekadu is a clinical professor of global mental health and the head of the World Bank Africa Centre of Excellence in Therapeutic Discovery (CDT-Africa) at Addis Ababa University in Ethiopia. He is also an African Research Leader of the Medical Research Council/DfID, UK, and fellow of the Ethiopian Academy of Sciences. Fedaku focused on CHWs by applying his experience with psychosis to CMDs. In Ethiopia there are 38000 CHWs working in the community-led health program. To discuss this complex issue, he used the acronym SALIENCE to emphasize his focus on the more salient aspects of integrating mental health care into community health programs.

- **Structures:** there are clear structures in the community health system that are critical to understand.
- **Activities and problem identification:** in depression, for example, it is difficult to explain the concept of depression to CHWs and service users. Salient problems including alcohol use and suicidality can serve as gateways for CHWs into depression and other CMDs.
- **Local culture:** includes where people go to access care as well as care providers.
- **Incentives:** money is an important incentive, but even more important incentives are good clinical outcomes for patients.
- **Equity:** valuing the role of CHWs, and treating them as equals, is hugely valuable.
- **Needs:** integrating mental health and others described above.
- **Community needs:** identifying community resources and working with those resources.
- **Engagement:** when community members see people with good outcomes from treatment, it mobilizes service use.
Supporting the wellbeing of CHWs is also critical, because they tend to have more mental health issues than other health providers.

5.4 WORKING GROUP ON SYSTEMS AND STRATEGIES FOR INTEGRATION: FIRST SESSION

A report-out presentation from the first session of the working group on systems and strategies for integration was provided by Inge Petersen and Giuseppe Raviola, Assistant Professor of Psychiatry and of Global Health and Social Medicine at Harvard Medical School, Director of Mental Health for PIH, and Director of the Program in Global Mental Health and Social Change at Harvard Medical School. Their presentation was framed by the visualization that was created by the group during the first session as a starting point for discussion (see Figure 53).

Figure 25. Systems and strategies for integration: working group presentation graphic

Source: Harvard Medical School Center for Global Health Delivery-Dubai, Working group on systems and strategies for integration 2018e.

5.4.1 Process of scaling up

Raviola opened by explaining key steps in the process of scaling up the integration of CHWs. CHWs should be integrated into a strong primary health care platform, he noted, with efforts to reinforce the primary healthcare platform taking place in parallel with those aimed at promoting and integrating care delivery and other activities by CHWs in the mental health space. The next step in the process is to select a pilot site to try things out at a very small scale. Subsequent stages include collecting data and experience, with continuous quality improvement as a vehicle for implementation. Effective partnerships with governance at district and national levels are critical in order to drive toward the
ultimate goal of the process: developing programs for scale.

5.4.2 Support, supervision, and referral systems

Petersen noted that it is important to have referral systems in place before engaging at the community level, so there is a referral system for the CHWs to refer up to into the system. This begins with strengthening referral resources in district-level primary health care facilities or district hospitals, such that there will be referral resources and support for supervision in place when engagement at the community level begins.

The map includes both a private sector and a public sector system led by a Ministry of Health, explained Raviola. The pre-service level may include providers who have been trained in psychotherapies at universities, which serves as a pre-service training apparatus. Local people may come out of formal, academic institutions locally, receive licensing and/or certification, and then enter the private sector. In some of the settings where he has worked, however, these higher-level supports do not necessarily come from academics who have a grounding in contemporary psychotherapies and CHWs may not have access to supervision. In those settings, supervision may come from psychologists or other mental health clinicians, such as psychiatric nurses, who are trained in something similar to psychotherapy but which is very context-specific. As a result, district hospitals are staffed with different levels of support for psychotherapy. Returning to the graphic, he noted that the district hospital may have higher-level supervision but again, this depends upon the context. In theory, CHW supervision would be housed at both the community and health center levels. The foundational level is the households in the community, he added.

5.4.3 Concepts

Raviola then turned to outlining some of the basic concepts highlighted by the working group, including:

- Building platforms for depression on the primary healthcare platform linked to communities
- People-centered care
- Continuum of depression
- Integrative concepts
- Phased approach of strengthening primary health care before engaging CHWs
- Linking depression care with priority wedge issues
- Context assessment of existing services
- Collaborative stepped care
- District mental health plan for depression
- Care pathways
- Mental health value chain
- Quality improvement methods

The primary health care platform is critical for developing a community platform for depression, so a fundamental concept is to build platforms for depression on the primary healthcare platform linked to communities.

The group discussed the importance of another fundamental concept: people-centered care, which could be defined as being non-authoritative and placing the patient in the lead. The community-oriented primary health care model should also be people-centered. He noted that this ties in with many of concepts discussed by the working group on CHW roles, tasks, and polyvalence.

The continuum of depression is rooted in Patel’s definitions of wellness, which includes mental health promotion and what might be called holistic care and integration. The community, the health center level,
and the district level are correlated to points on the continuum, with wellness and distress management situated firmly in the community. Depression care is placed at the edge of the health center and the community, with care for recurrent and refractory depressive disorder at the health center level and leaning toward the district hospital. The stepped-care model of health center and community screening as well as the stepped-care model of mild, moderate, and severe depression are also included. In PIH programs, people with mild depression would be followed back to the household by a CHW, as is the practice in PIH sites in Rwanda, Mexico, Haiti, and (soon) Liberia. Moderate depression receives psychosocial and therapeutic support; severe depression receives psychosocial and medication from physicians. On the left of wellness to distress on the continuum are mental health promotion and self-care. Slightly to the right are culturally oriented focus on community solidarity, screening, psychoeducation and prevention, and referral. Moving to basic support, follow-up, and case management, Raviola remarked that the term basic support became controversial among the group, which is consistent with the general discussion. Moving on to questions about polyvalence and the realities of national scale bumps up again against the question of whether basic support is a pipe dream. “How can we define basic support in a way that makes it feel feasible,” he asked, “while still accepting in some contexts it’s not feasible?”

Noting that the depression continuum is depicted in the map as somewhat of a standalone for mental health promotion and self-care. Slightly to the right are culturally oriented focus on community solidarity, screening, psychoeducation and prevention, and referral. Moving to basic support, follow-up, and case management, Raviola remarked that the term basic support became controversial among the group, which is consistent with the general discussion. Moving on to questions about polyvalence and the realities of national scale bumps up again against the question of whether basic support is a pipe dream. “How can we define basic support in a way that makes it feel feasible,” he asked, “while still accepting in some contexts it’s not feasible?”

Integrating depression care along these programs is critical, he emphasized.

The next concept is the phaged approach of strengthening primary health care before engaging CHWs in the care of illness. Capacitating primary health care includes increasing supervisory resources and putting CQI in place.

Linking depression care with wedge issues that are priorities like HIV, maternal health, and psychosis is another key concept. In Rwanda, they have dealt with psychosis and are now piggybacking depression care on to that system, he noted. In Liberia, they have been taking care of homeless people, people with psychosis, former combatants, and other people with mental health needs in the community. CHWs are delivering medications by motorcycle to homeless people who have now reconnected to their families. They are now able to work on piggybacking depression off of “busting the stigma” in the community. It is important to think strategically about the priority condition that the system is being articulating around, while also accepting the fact that comorbidity is the rule and inevitability this will entail dealing with psychosis, depression, trauma, epilepsy, alcohol use, and so forth. However, the idea of linking depression to wedge issues is currently gaining momentum at various sites. He noted that PIH has a huge push toward maternal child health for example. Integrating depression care into maternal health clinics and HIV may be low-hanging fruit, he added.

Context assessment of existing services is the next concept. This includes existing cadres of providers, mapping the skills onto the existing system, identifying needs, and then understanding local perspectives and priorities. This might involve some qualitative work to understand local perspectives within the health system and community.

In the context of collaborative stepped care, Raviola referred to the paper on internal stepped care and flagged that it would be useful to explore further.83 Within this model,
that type of thinking outside the box would help to predict people lost due to the level of degradation in the health system.

Existing literature describes how to create a **district mental health plan for depression**. He suggested revisiting the literature to consider ways to embed depression care in those district-level plans. Additional concepts include the concept of the **care pathway**, the **value chain** concept and mapping the components onto the system, as well as **quality improvement** methods.

### 5.4.4 Crosscutting issues

Raviola highlighted a set of crosscutting issues: **training, supervision, mentorship, clinical management, academic capacity**, and **research capacity**. They are all separate, but also linked—it is important to be clear about the importance of all of them, as well as their different meanings. Additional crosscutting concepts include **safety, quality measurement, monitoring and evaluation, performance**, and **CQI**.

He recounted that in Rwanda, a very small team of Rwandans works under the district medical officer for health for PIH, who has been twinned with the government district clinical leadership. The local team started to develop quality improvement trainings from the outset. By developing circumscribed quality improving projects, they were able to generate the most basic level of data needed to apply for grants and to improve care at the district hospital. They have since had multiple fellows in global mental health delivery, one of whom worked with a team to eliminate transfers to the national hospital as the first CQI project. After eliminating transfers and building up the formulary in the district hospital, the team looked at medical records to find who was coming to the hospital. Then they started a pilot aligned with the process just described: a very circumscribed, mentored, and enhanced supervision of health center nurses and the evaluation of treatment for psychotic illness. They started with psychotic illness (rather than depression) because they knew people were being chained at home and CHWs were bringing people in; people were walking 50 km catatonic to the hospital. Then the system burgeoned from three health centers to 20 and they have collaborated with the Kenya World Vision team to implement integrated Problem Management Plus care. The health center nurses are now providing depression care, but there is also a downward cascade of CHWs and other groups now becoming involved.

### 5.4.5 Technology

In the context of technology, the group recommended that implementers should leverage what is already being used in the context, rather than trying to do new things. The promise of technology is great, said Raviola, and trying to leverage what is used in context is critical. Also critical are improving health information systems (HIS) as well as learning systems and collecting good quality data, because “good quality data coming in yields positive results out.” Technology should also be used for training and supervision under the umbrella of strong government support and policy, he added.

### 5.4.6 Discussion

During the large-group discussion that followed the presentation, participants discussed system planning and design considerations, funding considerations, and suggestions to improve engagement.
5.4.6.47 System planning and design considerations

5.4.6.47.24 Health system building blocks framework

Haifa Madi (Ministry of Health, UAE) recommended restructuring the mapping exercise using the six building blocks of health systems. These include stewardship and governance, workforce, financing (from donors or government), incentives for health workers, the workforce for service delivery (be it vertical or horizontal), and primary health care. The structure needs to be flexible to be applicable to more countries. She suggested that this framework would enable easier context assessment and provide a clearer visual with which to move forward.

5.4.6.47.25 Learning from humanitarian work

Systems-wise, there could be some lessons to be gleaned from the humanitarian side, said Alison Schafer (World Health Organization, Geneva). The humanitarian side has somewhat figured out the integrated care approach which is the basis of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007),84 which could also be relevant to development.85 The other learning from humanitarianism that could benefit this kind of system are the implementation coordination groups that look across the combined government, NGO, and United Nations sectors to establish a coordinating function across the country. That can largely be managed at the ministries of health, she suggested, and it has the potential to reduce vertical programming as well as promoting horizontal integration.

5.4.6.47.26 Focus on priority condition versus transdiagnostic focus

Schafer challenged the group’s recommendation to focus on one priority condition, given the evidence base for transdiagnostic interventions and treatments that encompass multiple NCDs at the same time. Vikram Patel (Harvard Medical School, USA, and Sangath, India) noted that this working group was tasked primarily with thinking about healthcare systems to support, enable, and sustain the integration of CHW interventions for CMDs; as such, the focus is indeed transdiagnostic in his opinion.

5.4.6.47.27 Settings without a functional public sector

Jimena Maza (Partners In Health/Companeros En Salud, Chiapas, Mexico) explained that Mexico has a health system, but it is nonfunctional. They have 100,000 mental health professionals, but no system to support them. Generalist CHWs are being used, but it is not sufficient, so they have decided to create a vertical CHW mental health program. Mental CHWs have been separating out from CHWs for chronic diseases and provided with capacitation as well as a care package for CHW wellbeing. “We know we need to take care of them and they need to take care of themselves,” she said “because we have seen how they’ve been affected by the programs they have been delivering in their communities.”

Raviola wondered if guidance should be provided for such settings without a functional public sector. In Mexico, for example, they have created a vertical program with a care pathway, a QI plan, and data collection. They are evaluating outcomes and clinical improvement; they are doing research, ensuring wellness of CHWs, they have integrated cognitive behavioral therapy and the CHWs are delivering it. They have support groups and they have psychoeducation groups. They are doing it all themselves in the absence of the public sector. “I totally understand the discussion about doing things in the public sector,” he said, “but there are places where there is no public sector. Could

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85 Inter-Agency Standing Committee 2007
we acknowledge that there could be different guidance for that kind of a situation?"

A participant related experiences from Rwanda. After 1994 genocide, there was one psychiatrist for the whole country and one psychiatric hospital located in Kigali City. The government started by creating vertical mental-health-specific programs at the national level, with a focus on policies, advocacy, and engaging with government sectors. The implementation was already integrated and centralized. He conceded that this approach would not work in all systems, but it is important for the integration to be as sustainable as possible to reduce the stigma around mental illnesses.

5.4.6.47.28 Systemic-level threats and risks

Patel raised the issue of potential threats and risks, such as overburdening CHWs and the stigma around mental health. He asked for thoughts on how to address the fact that many of CHWs are reluctant to treat mental health because of that stigma. He suggested identifying systemic-level threats that need to be addressed by proactive strategies.

5.4.6.47.29 Embedding community health workers in health systems

Patel asked for reflection on how the CHW is embedded within the healthcare systems, both in terms of the primary care facilities (because some individuals require antidepressants, for example), but also further up the system for those who need more specialized mental health care. He asked the working group to grapple with the core process of coordinated, seamless embedding so that the CHWs are not working out on a limb, but cooperating as part of a collaborative team across the different sectors and levels of the health system.

5.4.6.47.30 Integrating with the broader global health agenda

Rabih El Chammay (Saint Joseph University, Beirut, and the National Mental Health Program, Lebanon) asked how the group’s proposal figures fit within the broader global mental health agenda. For example, he questioned whether they should advocate that funds be invested exclusively in service provision and a community mental health worker programs, or whether some of the funding should go toward leadership and governance, health and medical information systems (HMIS), and so forth. He contended that programs focused only on service provision risk failure if there is not concurrent work to establish structures and critical governance mechanisms at national levels. Jordans agreed, noting that the PRIME and EMERALD programs had research initiatives in place when there were very few services in the system. They used these programs to put services in place as well as to strengthen the entire system, which can escalate to elements like HMIS, policies, changing the essential drug list in the country, etc. The challenge is that when funding comes in, decisions have to be made about how to use it most effectively across these pieces, he added.

5.4.6.48 Funding considerations

5.4.6.48.31 Leverage existing structures and systems

Jafet Arrieta, Director and Improvement Advisor for the Institute for Healthcare Improvement, reported that the working group reflected on the hypothetical scenario of being offered US$100 million for an actionable plan. Given that most health systems in these contexts are fragmented and complex, a comprehensive approach is required to integrate mental health care. It would be an opportunity to use vertical funding to build horizontal systems integrated into primary care by leveraging the existing structure in the country. The first step would be a landscape analysis to understand the existing resources, existing mental health plan (if any), and the setting’s capacities in terms of human resources and infrastructure (e.g., hospitals and primary care clinics). The analysis would expose gaps along the continuum of care that could then be addressed in a more organized fashion, she said.
5.4.6.48.32 Strong governance to address maldistribution

Maza highlighted the importance of priority alignment and coordination within the governance system. Governance structures should be responsible for effectively and equitably distributing human resources to avoid such situations. In Mexico, the number of psychiatrists is adequate, but they are mostly concentrated in Mexico City. The problem is not the lack of human resources for mental health or healthcare in general, it is the maldistribution of those resources. She contended that funding should not be invested into service delivery without changing and improving governance and workforce structures, if the aim is to reduce the disparity in mental health outcomes and system across the country. The phased approach is the most effective way to address inequities and scale up interventions country-wide.

5.4.6.48.33 Mitigating dependence on donor funding

From a more upstream perspective, Arrieta said the group also contended that for the US$100 million to produce value, it should be used to work with the health system to establish a strong governance system or structure. Many of these countries are dependent on foreign aid, and a strong governance structure would build the capacity to regulate the NGOs or foreign aid and enable them to dictate how the money is invested, thus ensuring that it is optimized.

Petersen said that the group discussed at length the use of donor funding, especially if it is substantial. It is important to guard against establishing a parallel service that creates dependency and as a result, makes it quite difficult to strengthen the existing system. Hence the importance of a “road map” created by identifying pilot sites and developing a pilot model that’s scalable—that is, starting small and building up from there. If donor funding is imminent, it is important to be very careful to ensure that money is used responsibly and to be vigilant against misuse, Petersen warned.

When possible, she suggested redistributing existing resources rather than implementing donor-funded resources. Middle-income countries such as Mexico and South Africa should have enough funding for mental health, but the existing resources are being maldistributed. “It’s pointless to use donor money to implement resources when we can just redistribute the existing resources,” she said, “because the former would create more chaos when the donors disappear. That’s what we’re experiencing with HIV right now…we need to be responsible.” South Africa is not yet redistributing resources, she added, but there are moves toward it as evident in the last district reworking.

Petersen remarked upon integrating vertical donor funds, which have earmarked only for mental health, by selecting a priority disorder to focus on initially and then leverage to develop other services. The phased approach will also go across stepped care, she added. The first step is establishing supervisory and referral structures, then moving backward into the community after those structures are in place. Once these basic principles are fulfilled, technical support packages can be developed and implemented using CQI. This serves both as a mechanism for creating roles and a driving force to bring people along with the policy changes needed to enable integration.

Patel cautioned recommendations should not be constrained by the funding source. That is, increased resources for mental health care should not always be seen as expendable donor money; much of it is internal money, which may be being misused or not used at all. The task at hand is to create a set of recommendations about how money should be used, regardless of its source. Although the source is an important consideration, he added, it should not constrain innovation in how to use funding. For 80% of the world’s population, it is no longer the case that donor money is financing healthcare. It is financed through local money, yet access to depression care is very poor. He urged participants not to let concerns over funding sources shackle their thinking.
5.4.6.48.34 Inclusion of budgeting guidance

Another option is to position the situational landscaping around using language that is more familiar and provides more context, said Dan Palazuelos (Harvard Medical School and Partners In Health, USA). $100 million sounds like a vast amount, but it is relatively little money in practice. UNICEF created a costing tool to estimate the cost per CHW per year to do a generalist Integrated community case management (ICCM) impact, which found that is costs around $1000 to $2000 per year per CHW, depending on the context. The next question is about the ratios; in a country of five million people with a CHW ratio of 1:1000 will require 5000 CHWs, amounting to a few million dollars a year. “A million dollars in India would go nowhere compared to Sierra Leone, where it would make the program sustainable for 3 years,” he remarked. That does not include the stewardship function or multisectoral defragmentation coordination that comes at an additional cost. He said that in Mexico, for example, the biggest problem is the fragmentation—they have seven different health systems that do not communicate with each other. Maza remarked that the PIH program in Mexico (Compañeros En Salud) is considering similar questions in their project—that is, whether to provide better incentives to CHWs. The country has only two psychiatric hospitals, which were closed because of the lack of a psychiatrist. The lack of professionals makes it difficult to decide whether to invest money at the community level or in a health system that is virtually non-existent.

Palazuelos suggested providing a blueprint or recipe for budgeting. There is an important distinction to be made in guidance, he added—whether to provide options for when you have no resources, or advising that programs need to have real funding to do something real (which he termed a best-buy versus a Cadillac program). He wondered, “Is a psychiatrist a Cadillac program? Is psychoeducation a low-hanging fruit/best buy? Where do CHWs fit in that continuum?” Petersen was concerned about recommendations around donor funding because it will create dependencies in the long run. Another participant suggested costing out multiple options and funding scenarios suitable for different levels of resources. If stakeholders know the resources available, whether they are minimal or ideal, it can cut down on dependence while also offering a chance to dream big.

5.4.6.49 Suggestion for engagement

5.4.6.49.35 Drawing from generic CHW literature to inform mental health engagement

Patel suggested that the working group could benefit from looking at the generic literature around sustainable training and supervision of CHWs in the broader global health canon. There is already literature about what has already been shown to work or what has been tested more broadly to support, enable, and sustain CHW engagement.86 This work can then be used to pick out those strategies that are especially relevant for mental health. For example, strategies associated with stigma that are underrepresented could be added on as specific to mental health.

Reflecting on his own experience with existing CHWs, Patel noted that questions recur repeatedly around how the system can make sure that workers are not overwhelmed and about models by which this existing workload could be reorganized or the per capita of each CHW reduced, for example. Of the various ways to think about this involves the injection of new resources. One strategy is to invest money not into a vertical program of CHWs, but into changing the existing CHW coverage of households. The ratios are changed such that there are fewer few households per CHW, but they are doing additional duties integrated in their own work. Another example is the incentivization of ASHA workers. Patel remarked, “What would be the financial incentives, for example, to deliver a course of

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86 Palazuelos et al 2018
treatment for depression. How do you cost it? We are essentially working out models incentivizing these front-line workers to deliver psychotherapy. Is it per session? Is it for a minimum number of sessions? Those are the types of strategies I think the group should consider in terms of sustaining CHW interventions.”

Petersen remarked that because resources are setting-specific, countries will need to decide which activities to assign generic CHWs. Generally, generic CHWs do basic health promotion, screening, and referral; adding on psychological treatments to all of their other tasks runs the risk of overloading them. She suggested that there may be other cadres in a system, who are also at a CHW-type level, that might be leveraged to delivery psychological treatments. “It’s difficult for us to make those calls, but the situational analysis really needs to be a part of the process,” she said. “It’s not a one-size-fits-all; it’s going to be leveraging what is there.”

Raviola suggested creating a visual of the potential options about the different combinations that are available in a system through which care could be delivered using the roles that are existing. Various combinations of providers could cover the different permutations across contexts. In Chiapas, for example, there are no psychologist or social workers, but there are CHWs. A visualization might help people more clearly envision the various combinations of mixing and matching services. Raviola noted that the issues of CHW mental health and wellbeing—which are tied to mentorship and support—had not yet been discussed. He suggested outlining different ways to support CHWs—e.g., academic, professional, personal, incentives, wellness, and self-care.

5.4.6.49.36 Engage other ministries to address social determinants

Arrieta remarked that at a higher level, the Ministry of Health should be encouraged to use its restorative function to bring other ministries on board, like the ministries of finance, economics, social inclusion, and so on. The other ministries need to understand how the social determinants of health act as triggers and causes of CMDs. The group discussed how it is not the exclusive responsibility of the health system to address the social determinants of health, but it is the responsibility of the health system to engage other stakeholders to make sure the determinants are addressed. “Otherwise we are going to keep addressing the symptoms,” she said, “but not the causes of the problems.”

5.5 WORKING GROUP ON SYSTEMS AND STRATEGIES FOR INTEGRATION: SECOND SESSION

Petersen and Raviola reported back from the second session of the working group on systems and strategies for integration. Relationships among components in a system are complex and mutually interdependent, Petersen reminded the group; tinkering with one component will affect other parts of the system. It is difficult to look at CHW interventions in isolation without looking at the entirety of the system, she said.

5.5.1 Key principles underpinning systems and strategies for integration

The group began their deliberations during the second session by identifying a set of key principles for integration and scale up of CHW care for CMDs in communities. The principles are shaped by the previous day’s discussion, said Petersen. An overview of the principles is provided in Box 51.
Box 9. Principles for integrating systems and strategies

- Strive for integrated people-centered approach rather than a vertical approach
- Provide technical support and clearly define the role of the technical support partner
- Engage with and receive support from government structures at all levels
- Make funding available to front-line providers within task-sharing model
- Identify priority platform in country
- Embed mental health as part of work of front-line workers
- If resources are insufficient or absent, partner or twin with existing resources, work with government structures to redistribute and/or acquire resources, and utilize donor money to support and develop supervision structures
- Adopt a co-designed phased implementation approach with governments, including health systems strengthening at multiple levels plus technical support to develop and implement district mental health plans.

The first principle is to strive for integrated people-centered approach rather than a vertical approach, with mental health situated firmly and strategically within the country’s NCD agenda. Ideally, the person would be treated holistically within this people-centered approach. A tension comes into play, however, in considering how to avoid overburdening general CHWs with activities related to mental health—a concern that has been a recurring theme over the workshop, Peterson noted. It is also important to be respectful in positioning both CHWs and care recipients. That is, mental health needs to be introduced in an ethical way both for the person who is receiving care and for the person who is providing that care. This relates to issues around licensing, she added.

Technical support is the second important principle that underlies the introduction and integration of community-based mental health activities. In addition to providing strictly technical support, the group discussed how the technical support partner should also provide strategic support, program management support, supervisory support, support in maintaining CQI, as well as guidance in utilizing existing resources whenever possible. That speaks to avoiding introducing resources to deliver the service and creating a parallel service which is not sustainable and creates dependency.

Another principle is the need for engagement with government structures at all levels and the need to receive the necessary support from those structures. Petersen noted that this ties into the deliberations of the working group on stakeholder and community engagement for taking interventions to scale. When financial resources are available, the funding must reach the front-line providers who are actually delivering the services on the ground. This may require developing targeted funding mechanisms within the task-sharing model.

To identify priority platforms for each country’s specific context, instead of trying to take on the delivery of care for all conditions, is another principle highlighted by the group. For example, the HIV delivery platform is a priority for the government of South Africa; the governments of other countries may have different priorities, such as maternal and child health. An additional principle is to embed mental health as part of the remit of front-line workers, said Petersen. This is aligned with the ethos of people-centered, integrated care. As such, mental health will not be perceived as an add-on, but instead as an
integral part of the CHW workload that is part of their job description.

In many settings, the resources of supervision, mentoring, and support for CHWs may be absent or insufficient. In such cases, one strategy is to **partner or twin with existing resources** to develop further resources. In cases where resources are **inequitably distributed or unavailable**, a guiding principle is to **work with government structures to redistribute resources and/or to acquire new resources**. Another strategy is to **utilize donor money to support supervision while working to develop local supervision resources**, such as training programs for specialists. Petersen added that if funds have been introduced to support service delivery and particularly supervision, it can be useful to develop MOUs to guarantee that the government will transition to take over that service within a specified timeframe.

The final strategies relate to perhaps the most important principle: to assume a development approach to **create a co-designed, phased implementation plan with governments**. As Petersen explained, this ensures that the services are not being imposed upon the setting in such a way that they would create dependency or other neocolonialist consequences. The approach should aim to **strengthen the health system at all levels**, given the interdependencies intrinsic to such systems. It should also include the proviso to provide technical support to **develop and implement a standard district-level mental health care plan**—that is, a template for a technical support package that can be implemented in other districts to scale up the program. CQI should be used to identify standards of practice and small policy changes that are needed to scale up to additional districts.

### 5.5.2 Community health workers within the framework of health system building blocks

Petersen and Raviola continued by framing the integration of CHWs into mental health using the building blocks of health systems: leadership and governance; the health workforce; financing; medical products, vaccines, and technologies; service delivery; and information. People sit in the middle of the framework and are the crux of the system (see Figure 26). They outlined sets of specific tasks, strategies, and principles that pertain to each of the building blocks.
5.5.2.50 Leadership and governance
A critical leadership task is to establish technical support units to support governments in implementing integrated CHW care in communities. A number of countries have established sound policies and plans, but they are not being implemented because people simply do not know how to do so. Also in the context of leadership and governance, it is important to enter into agreements with governments surrounding the role of donor funding agencies and technical support partners in order to avoid developing parallel services. In settings where donor funds are used to finance services, there should be MOUs in place regarding the transition of those donor-funded resources back to the government after a finite amount of time—e.g., for the government to take over supervision and support. Establishing multisectoral government structures at all levels is a fundamental principle. CHWs need to be part of the policy framework for delivery of services.

5.5.2.51 Health workforce
In terms of the health workforce, a key activity is to map CHWs and supervision tasks against the existing resources. CHW tasks should be shared across different CHW groups to prevent an overload on individual CHW. It is also important to push toward certification and regulation of CHW activities, as well as revising core competencies, job descriptions, as well as pre-service and in-service training for task sharing among CHWs, specialists, and all other levels of care. It may be necessary to provide transitional supervisory and supportive resources if they are limited or unavailable in the setting. Information
technology can be utilized to overcome supervisory resource constraints as needed.

5.5.2.52 Financing
In the domain of financing, implementing partners should work with governments to redistribute specialist resources in countries, if possible. In many settings, specialists are inequitably distributed and skewed more heavily in urban areas versus rural areas. It may be helpful to provide transitional budgets for CHW posts, supervisors, and mentors in settings with weak primary health care systems. Ring-fencing of the mental health budget is another recommendation, particularly at the lower levels. The responsibilities for coordination will vary across different contexts on who that might be—academia or district teams, for example.

5.5.2.53 Medical products, vaccines, and technology
With respect to medical products, vaccines, and technology, it is important to ensure that there are operational manuals and standard operating procedures, as well as technical guidelines and manuals. This serves to support and strengthen health worker supervision and communications around supply chain management. This is particularly critical in settings where CHWs are charged with delivering medications. Existing information technology platforms can be leveraged for mental HIS. Strengthening telehealth supervision structures and supply chain management are additional tasks needed.

5.5.2.54 Information
In the context of health systems, information-related key principles include integrating the key performance indicators and targets for CHW tasks into the health management and information systems. Service delivery in particular requires strengthening the primary healthcare service writ large during the process of integrating mental health. CQI should be used as a vehicle of change to catalyze the transition to integrated care.

This requires establishing a monitoring and evaluation framework, which should include operationalizing those key indicators and targets for CHW tasks within a CQI framework.

5.5.2.55 Service delivery
With regard to broad realm of service delivery, the group focused on providing a road map and guidance for how settings can go about introducing integrated mental healthcare through CHWs. This includes strengthening the Community Oriented Primary Health Care (COPC) platform in areas where it is weak. Collaborative care models that include CHWs and link directly to community supports and development agencies should be developed and/or strengthened as well. CQI methods should be used to introduce changes in the care pathway along a continuum of care.

5.5.2.56 People
People are the most important cog in the wheel. They should be bolstered by establishing a solid foundation of CQI structures at the community level to build will, while also monitoring and evaluating progress. The structures should encompass CHWs, community representatives, the health sectors and other sectors, and NGOs—all of whom should play a part in the process of developing and integrating services, monitoring how well they are doing, problem solving, and system strengthening. This promotes more community control, which is the ultimate aim.

5.5.3 Process for setting short- and long-term goals with existing resources
Petersen and Raviola then turned to the process for determining short- and long-term goals that are feasible given the setting’s existing resources. This serves as a kind of road map for how governance at the national as well as provincial or local levels can go about developing a system to support CHW activities. The aim is to develop those care pathways using existing resources for priority disorders along the continuum of care. The process involves carrying out a situational
analysis, then developing care pathways and mapping CHW roles.

5.5.3.57 Situational analysis
The first step is to perform a situational analysis. This should include assessing the burden of illness of CMDs in the setting, as well as the resources and services available in the area being targeted. The analysis should evaluate the activities of existing CHWs cadres—which may differ across sectors—to determine who among them could be deployed to share the workload of mental health activities. It should also include an analysis of existing management and supervisory capacities that could be further developed and leveraged to integrate mental health.

5.5.3.58 Developing care pathways and mapping roles
The next step is to look at how to use those existing resources to develop care pathways along the continuum of care for the priority conditions being targeted. Once the care pathway has been identified, the next step is to map the roles and functions of the existing CHW cadres onto those care pathways. The roles and functions of aspirational CHW cadres should also be mapped, even if donor funding is required to provide those services. At that point, capacity and resource needs should be identified—both for immediate needs and for long-term needs.

5.5.4 Strengthening public sector health delivery systems with community health workers
Figure 55 illustrates how public health delivery systems can be strengthened through CHW-delivered mental health care. It depicts a fairly typical system that may not apply to every setting. In the community, there are traditional forms of healing which occur at traditional health systems and places of worship; faith healers and spiritual leaders provide an important role in many contexts. Within the community, there are reciprocal referral flows of people between their homes and local health centers, facilitated by CHWs who have been trained in health promotion, case finding, referral, adherence, and follow-up. Health centers offer standardized screening, assessment, and treatment, including support for behavior change and care management. People may be referred to district hospitals for specialty health services that are coordinated with health center and community-based care; they can also direct patients to national referral centers for mental health care. In this exemplar, CHWs work across the entire system.
Figure 27. Strengthening public sector health delivery systems with CHW-delivered mental health care

Source: Harvard Medical School Center for Global Health Delivery-Dubai, Working group on systems and strategies for integration 2018e.

5.5.5 Embedding the mental health care value chain for common mental disorders within the existing mental health system of care

Raviola presented a revised version of the map his group presented the previous day, which they had updated and adapted based upon feedback during the discussion (see Figure 56). He emphasized that the care pathway is one of the two essential components in delivering psychological treatments and/or other types of services and care for CMDs. A care pathway is critical in asserting that depression does in fact exist, he added. The second essential component is the mental health value chain. The care pathway and value chain also serve as the framework upon which to hang the CQI infrastructure. It is also important to acknowledge the private care system and consider how universities and academic centers feed into the system.

Raviola pointed to the continuum of depression: from wellness to distress to depression and then to recurrent, refractory depression. The specifics may be fleshed out vis-à-vis the work presented by the working group on CHW training and supervision, but his group sought to capture the fact that the “dividers” in the continuum are flexible and mobile. The model can thus be adapted depending upon the specific system, including critical (and controversial) considerations around when it may be appropriate to deliver more focused psychotherapeutic interventions at a community level, as opposed to prioritizing a path to scale and polyvalence. The terms “innovation” and “standardization” are used to capture the idea that as one moves leftward on the continuum into the community, the use of psychological treatments may be more innovative. Given the focus on the flexibility of systems, he added, this feature was important to build into the map.

The crosscutting issues of training, supervision, and mentorship span the clinical, management and academic spheres, said Raviola. He noted that the role of academics feeds into discussions about how to build research capacity for CHWs. Safety, quality, measurement and performance improvements are also cross-cutting to this model. Ultimately, it would be useful to superimpose those features as a third layer on the model.
Petersen referred back to Figure 28 from her presentation, an example of how to map CHWs onto a local area, in this case a particular district in South Africa. In this district, there are general CHWs as well as a subset determining how they would diversify their role to expand from HIV counseling alone. Aspirationally, they wanted a behavioral health subset to do more focused psychological interventions. The exercise demonstrates how they needed more resources in terms of supervision capacity (including psychologists, social workers, and occupational therapists) situated at the district level.

A participant noted that there is also a practice that involves mapping skill packages onto the existing system and resources. This was carried out in Rwanda as part of the process of reconfiguring the strategy for mental health. The process may involve identifying existing CHWs and their particular tasks and mapping them onto the specific care pathway. Roles might be assigned through color coding based on general knowledge, skills, triage, engagement, education, support, psychology therapy, pharmacological therapy, specialists care referral, quality and oversight. Another option is to ignore the specifics and create a generic pathway for depression, involving the health center, community screening, and then triaging to mild, moderate, severe. Mild cases would receive home-based care by a CHW and moderate cases might be referred to someone in the system with the appropriate, context-specific skills. If the system includes physicians who can prescribe medications, they might receive referrals.

### 5.5.6 Considerations for local- and national-level governance

Petersen concluded by outlining a set of proposed considerations to guide for...
local- and national-level governance. The first is to align mental health task with existing tasks being carried out by different cadres of CHWs; ideally, their new mental health activities are not completely dissimilar to tasks they are already comfortable carrying out. CHW mental health tasks should be allocated across different groups of CHWs, to distribute the burden more equitably and prevent overloading certain individuals or groups. Detection and identification are also important considerations that should be linked to psychological first aid, she said. The group debated the value of implementing mass screening by CHWs if there is no referral system in place for people detected by the CHWs. To avoid this type of situation, the group recommended building a continuum of care to support CHW activities, including a referral system, according to Petersen. The group cautioned against assigning psychological treatment tasks to CHWs without building in the appropriate supervision and support structures. Finally, they suggested a set of countries that could provide instructive case studies of different scenarios, which could inform further discussion. The countries include South Africa (upper middle-income country); Pakistan; Haiti; Mexico (upper middle-income country); Ethiopia; Indonesia; India (middle-income country); and United States.

5.5.7 Discussion

5.5.7.59 Standardized processes and procedures

During the discussion, a participant suggested adding standardized processes to clarify the processes and workflows for each CHW. This would help ensure that the system is organizational rather than individualized. For service delivery, structured processes prevent personalization by each person. Raviola replied that the value chain is intended to provide that structure, which facilitates evaluation and management of different facets of the process. Petersen agreed that there should be a higher degree of structure and standardization around training and work processes.

5.5.7.60 Complexity of the model

Several participants commented that there might be too many frameworks and the model may be too complex, but Petersen said that at the local level, the stark reality is that people simply do not know how to implement without assistance. Just providing the building blocks is not sufficient, she added. Madi clarified that the six building blocks serve as the general framework which can then be fleshed out and expanded upon to the level of detail required. Patel and Petersen commented that the work of the five groups needs to be integrated and finessed to streamline and eliminate overlap.

5.5.7.61 Multilevel improvement

A participant suggested that improvement science requires distinct macro-, meso-, and micro-level approaches. The macro level would involve strengthening the system and its component building blocks. The district is the meso level, which requires implementation strategies. At the micro level, rapid situational assessments are required to address the value chain, ensuring different approaches.

5.5.7.62 Psychological first aid without a referral system

A participant asked about providing psychological first aid without a referral system in place. Petersen contended that it is preferable not to introduce screening without support, but it depends upon how screening is defined. Eddy Eustache, director of the Psychosocial Services at Zanmi Lasante (Partners In Health in Haiti) said that in Haiti, there is a saying that “situations commence actions.” They have provided psychological first aid in Haiti, when they had patients suffering with depression who lived in such remote areas that they could not afford to travel to where CHWs were working to access help. To address this, they trained lay health workers in the basics of interpersonal therapy, so they could go to patients’ homes to provide empathic support, relaxation, and give hope.
worked, he said, and these lay workers are now iconic figures in Haiti. CHWs have practice in interpersonal therapy and the outcomes are evident, he added. Arrieta commented that in Mexico, if there is no place to refer, sometimes they will refer to general practitioners who are trained in mental health or, if that resource is not available, they may refer social workers trained in psychological first aid. She argued that it is very important to train CHWs in psychological first aid to prepare them for the eventuality that they will encounter someone who is suicidal, so they will be equipped with a basic and straightforward way to help the person.
6 Stakeholder and community engagement for taking interventions to scale

6.1 INTRODUCTION

Chapter 6 summarizes the workshop’s content related to stakeholder and community engagement for taking interventions to scale, including the review presentation, panel of expertise, and report backs from two sessions of the working group’s deliberations. This working group was asked to define the role of community and wider stakeholder engagement in enhancing the effectiveness of community health worker (CHW) interventions for common mental disorders (CMD).

The working group was asked to consider who the key stakeholders are and how to incorporate critical stakeholder feedback into the design and delivery of CHW interventions for CMD. They discussed the key components of effective engagement with Ministries of Health as well as other national- and district-level authorities around implementation of CHW-delivered interventions for CMD as well as the key components of effective engagement with communities around implementation of CHW-delivered interventions for CMDs. Given that these engagements require tremendous time and commitment—often when working with small teams and with limited resources—they explored how teams might be organized and mobilized to keep partners updated and informed and to maintain effective collaborations with governments, communities, and other stakeholders. Finally, they discussed how stakeholder engagement could be used to generate finances for supporting and sustaining these interventions.

6.2 STAKEHOLDERS AND COMMUNITY ENGAGEMENT FOR SCALING UP INTERVENTIONS FOR COMMON MENTAL DISORDERS: REVIEW PRESENTATION

Rabih El Chammay is a psychiatrist and the head of the National Mental Health Program at the Ministry of Public Health in Lebanon. After founding the program, he led the development of the first National Mental Health and Substance Use Strategy 2015-2020, which is aimed at reforming the mental health system in Lebanon toward community-based mental health services. He reflected on his experiences working in Lebanon to engage with stakeholders. Although there are no CHWs, there are many health providers with whom they are trying to engage. Located on the Eastern end of the Mediterranean Sea, Lebanon has a population of almost 6.1 million people, around 180,000 of which are Palestinian refugees. The country has a long history of civil war and political unrest, and the recent Syrian crisis led to a surge of refugees into the country (in 2013, 25% of people living in Lebanon were Syrian).

6.2.1 Landscape of the health system in Lebanon

El Chammay provided an overview of health coverage in Lebanon. Almost half of the population has no formal insurance and thus are entitled to coverage by the Ministry of Public Health (MOPH). Others in the population are covered by six public funds (social security fund: 28%; civil servants cooperative: 5%; four military schemes: 9%, private insurance and mutual funds: 12%).

87 El Chammay 2018
88 Ibid
89 Ibid
90 Ibid
He noted that private insurance schemes often do not cover mental health. Almost all health care is delivered in Lebanon’s strong private sector, which comprises 75% of hospitals beds and 90% of ambulatory care facilities in the country. The system is plagued by oversupply and supplier-induced demand, with a high relative rate of physicians (32/10,000 population) and ample medical equipment. The health system is very fragmented, with both overlaps and gaps in coverage. This fragmentation weakens the bargaining power of public funds and hinders planning and regulation, due to the inability to glean a complete picture of the system. It has also created risk pooling issues and fragmentation of service provision across the public and private sectors—for example, there is no formal referral system for patients through the different levels of health care. However, El Chammay said that this fragmentation also creates much room for innovation. Vertical programming of good quality has begun to be implemented.

El Chammay provided a snapshot of the mental health system in Lebanon in 2015:

- No mental health department in the MOPH.
- No national mental health policy.
- Gaps in mental health legislation related to promotion, protection and regulation.
- Chronic under-funding and tendency to fund curative, hospital-based care.
- Majority of insurance schemes do not cover mental health care.
- Under-staffing and concentration of human resources in private practice.
- Non-specialized staff not well-equipped to offer mental health care.
- High stigma, low levels of public awareness about mental health, and misconceptions about treatments contribute to discrimination in service delivery and to low rates of treatment seeking and service utilization.

- Lack of service research and absence of indicator-based mental health information system.

The humanitarian response to the Syrian refugee crisis led to the establishment of the Mental Health and Psychosocial Support task force as a coordinating mechanism for the mental health response to the crisis, said El Chammay. Co-chaired by the Ministry of Health (MoH), WHO, and UNICEF, the task force includes almost 60 actors. In 2014, the National Mental Health Programme was launched with the support of WHO, UNICEF, and the International Medical Corps, followed by the launch of the first national mental health strategy the next year. The strategy’s founding vision encompasses all people living in Lebanon, not just Lebanese nationals: “All people living in Lebanon will have the opportunity to enjoy the best possible mental health and wellbeing.”

6.2.2 Stakeholder engagement in Lebanon

El Chammay described four strategies used to engage stakeholders in Lebanon to strengthen mental health care. The first was to establish a roadmap with clear objectives and roles—in this case, accomplished by Lebanon’s national mental health strategy. The second phase was to map all relevant stakeholders, including:

- User and family associations
- Municipalities
- Other national ministries
- UN agencies
- Health providers including NGOs, primary health clinics, community health centers, and hospitals

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91 Ibid
92 Ibid
93 Lebanon Ministry of Public Health 2015b
94 El Chammay 2018
95 Lebanon Ministry of Public Health 2015a
He described some of the complexities at play among stakeholders in implementing a single straightforward intervention, such as training a psychologist on interpersonal therapy. The first step was to liaise with the funder, then to obtain an endorsement from the local association of psychologists. The next steps involved talking with the NGO to coordinate training and supervision, and then ensuring that the local university would be able to take over from the NGO. When the current funding stream ended, another funder came on board. Now there is a pilot ongoing in one center to test the implementation of IPT in primary care within a collaborative care model.

After the stakeholders were identified, the third phase was to conduct a stakeholder analysis to pinpoint areas for collaboration and synergy as well as find ways to motivate stakeholders to take part (e.g., financial incentives, capacity building, certification, and alignment with their respective agendas). In another intervention in Lebanon, the primary care department at the MoH was working with the World Bank to scale up universal health coverage. Mental health was not included in the five health packages proposed, however they decided to pay to train providers on mental health anyway. Five years on, the pilot ended but the World Bank decided to fund a larger budget with four packages for mental health (depression, alcohol use disorder, substance abuse, and psychosis) in 40 primary care clinics and 12 community mental health centers.

The fourth phase was to develop clear governance frameworks with hard tools, such as laws and contractual agreements. Soft tools within such frameworks include MOUs, ministerial decisions, circulars, accreditation criteria, and normative documents (e.g., psychotropic medication lists and recruitment criteria for mental health workers). Coordination mechanisms should set an annual action plan.

Reflecting on lessons learned during the engagement process, El Chammay emphasized the importance of connecting stakeholders together for better synergy. It is also important to foster and nurture relationships: “everything is personal and nothing is professional.” He recommended apologizing for mistakes, helping others to grow, and offering public recognition for jobs well done. He concluded the session by outlining a list of meta-factors at play that can contribute meaningfully to stakeholder engagement (see Box 61).
Box 10. Meta-factors of stakeholder engagement

Rabih El Chammay outlined a list of “meta-factors” that can contribute to strengthening stakeholder engagement:

• Garner high-level political support within the ministry and good collaboration with other departments (e.g., HIS, primary care, and maternal and child health)
• Create a critical mass or network of like-minded public mental health professionals nationally and internationally
• Mainstream in other sectors, such as sexual and gender-based violence, child protection, and education
• Think laterally: for example, nudging to increase adherence, human-centered design, technology, systems thinking, and human resources and organizational management
• Synergize different agendas, such as the humanitarian and development agendas or the protection and health agendas

Source: El Chammay, Presentation at Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders 2018.

6.3 PANEL: IMPLEMENTERS’ EXPERIENCES IN COMMUNITY ENGAGEMENT FOR SCALING UP INTERVENTIONS

The panel on community engagement for scaling up interventions was moderated by Rabih El Chammay. Expert implementers were asked to reflect on their experiences in the field to highlight key components of effective engagement with communities, Ministries of Health, and national and district authorities around implementation of CHW-delivered interventions for CMDs. They described tactics for organizing and mobilizing small teams with limited resources to keep partners updated and informed and to maintain effective collaborations with government, community and other stakeholders. They also provided guidance on convincing donors to invest resources in stakeholder engagement, with particular focus on framing the need for resources for stakeholder engagement to donors, particularly as it relates to CHW-focused service delivery.

Panelists included:
• Pamela Collins (University of Washington, USA)
• Panelist from Dubai
• Farah Aqel (Dubai Health Authority)
• Marlene Montoya (PIH Navajo Nation / COPE)
• Garmai Cyrus (PIH Liberia)
• Eddy Eustache (PIH Haiti)

Pamela Collins is a psychiatrist and mixed methods researcher with more than 20 years of experience in the field of global mental health. She is Professor of Psychiatry and Behavioral Sciences and Professor of Global Health at the University of Washington, where she directs the Global Mental Health Program. As a past director at the National Institute of Mental Health, she launched the Grand Challenges in Global Mental Health initiative and established a program of global mental health services and implementation science research in low- and middle-income countries. She currently serves as a commissioner for the Lancet Commission on Global Mental Health.

Most of Collins’s experience has been in working with severe mental illness, but she also has experience from the funder’s perspective. She is currently working in a
new setting, a high-income country with relatively limited resources for mental health services. The key question, she said, is how to engage the government, in particular, around implementation of task shifting or task sharing. She provided an example from her experience working in the northwest of United States, where the most salient questions centered upon how to define this cadre of provider: who are CHWs? What is their training, and what licensing issues are relevant? How it can be ensured that this person is doing something that can be vouched for by, for example, whatever local authority is responsible for ensuring that it is being delivered with quality and fidelity? How does this cadre of CHWs fit into the workforce?

Her institution is responsible for delivering mental health services in a five-state area, and these are some of the questions at hand. In Washington State, for instance, some of her colleagues are considering what kinds of training could be officially developed that can then create additional cadres of providers per state processes. This requires engaging with community colleges and local universities as well as accreditation bodies. The other question she responded to concerned key components of effective engagement with communities. This example comes from working with an NGO focusing on vulnerable populations in a high-income setting. First, understand the structure of the community and be aware of the attitudes around mental illness. In her example, the NGO was primarily caring for patients in the community with HIV who were immigrants. Issues arose around how to talk about mental health, especially when the person has an already stigmatizing medical condition such as HIV: A provider at the NGO explained one difficulty: “I feel like if I bring something up about their mental health, I’m making an accusation.” The other issue was around screening people for mental health problems. In clinical settings clients sometimes were offended when asked about their mental health or about whether they have considered suicide without already having an established relationship with the provider. As someone coming into the community to try to engage with people, it is important to get to know people and to find culturally acceptable ways and contexts to ask questions. She advised getting to know communities and being honest with them about what is being planned, as well as taking time to listen and spending time with communities. When working with the NGO, they spent a lot of time engaging with people delivering services on the ground, other cultural organizations, and clients themselves to understand their fears and concerns about mental healthcare. To convince donors, she suggested that one of the most important tasks is convincing them of sustainability. Convince them by highlighting ongoing engagement with the communities, with the government, and with people who will enable CHW programs to last beyond the randomized controlled trial or the pilot study.

The panelist from Dubai noted that the city has been developed only over the past 50 years, which presents both opportunities and challenges. Although the city is grand, with investment from visionary leadership, there are still challenges in scaling up services and maintaining the pace of development of the city. Dubai is currently an observer but hopes to soon become a participant in the global mental health movement. She noted the lack of government representation at the workshop, suggesting that there is much benefit in considering the roles of governments in these national and international global health strategies and plans that can be implemented effectively through negotiation and delivery across all stakeholders. In Dubai, for example, there are considerations around how to serve a population with a high proportion of expatriates (only ten percent of those in Dubai are Emirati). Strategies and implementation plans for building these communities from the ground up also need to focus on engaging with stakeholders who may be transient. Framing the questions in terms of integration and collaboration is key, she
added, to bring together the right people to safeguard and nurture the wellbeing of the population from a macro perspective. This cannot be operationalized by a single entity or a monoclonal vision restricted to the health perspective, she said, but rather a binocular perspective that takes into account both health and social lenses.

The Dubai Disability Strategic Plan 2021, for example, looks at thematic-based strategic aims for building inclusive societies and social cohesion measures that force the existing vertically structured systems to coordinate and collaborate to develop strategies that operate within key governance models with stakeholder representation. Sometimes this process may involve top-level higher committees with director generals across all sectors. For example, the Dubai Disability strategy looks at representation of different government agencies, stakeholders, and NGOs to deliver continuity of care and building in evidence-based interventions. Doing so will require bridging the gaps to improve accessibility, equity, acceptability, and scalability based on evidence-based political interventions that need to reach across 12 languages, in some cases, to outreach to the entire community. Within the government’s framework for stakeholder engagement, horizontally structured interventions are preferred over vertical ones. Bridging system gaps will require improving equity of care and reducing morbidity. The panelist from Dubai raised the issue of functionality using Dubai’s disability agenda, which is designed to mitigate socially determined barriers.

“With vertical structures, you’re forced to look at impairments and DSM-5 driven perspectives on mental health,” she said. She called for looking at the disability agenda from a functional perspective, taking into account institutional and socially determined barriers at both the individual and societal level. In Dubai, they are focusing on the systematic reduction of barriers – making this a mandate for all through data and key performance indicators (KPI). KPIs cross the breadth of sectors strategies, making all stakeholders responsible for mental health and disability, whether they are in the health, social, education, transport, or other sectors. A monitoring and evaluation framework has been created to ensure that those indicators, objectives, and targets are achieved.

Farah Aqel is a strategic planning specialist at the Dubai Health Authority. After 12 years of clinical experience at the Department of Health and Medical Services (DOHMS)-Dubai, she moved to management and planning. She has participated in key projects including the first mental health strategy in the Emirate of Dubai (Mental Health Strategy 2017-2021). Aqel shared a personal experience with the executive council, where she conducted a trial with adolescents and the creative lab. Two groups were involved. The professional group was comprised of providers and public and private stakeholders across the local and national level from a range of sectors: social, education, health and legal. The community group consisted mainly of adolescent students studying things unrelated to mental health (IT, engineering, etc.). She reported that the students were extraordinary collaborators. When asked if they read about mental health to learn or to challenge their parents, they replied that both were motivations. “The new generation we are facing is dynamic and challenging,” she said, “which we need to consider in our future planning.” Patients, families, and providers all need to be included; healthy people should also be more equitably involved than they currently are, in order to focus on prevention, promotion, and early intervention as well as service delivery.

Aqel described Dubai’s first mental health strategy (2017-2021), which consists of four pillars: government and regulation; prevention, promotion, and early intervention; workforce, infrastructure, and innovative service delivery; and recovery and community integration. Nine initiatives are underway under the themes of legislation and governance, early intervention and health promotion, innovative
service delivery, and patient empowerment. Guidelines are being created to guide governance and regulation, with a particular focus on a policy environment that protects government-employed CHWs and other service providers. Frameworks, guidelines, and standardized policies and processes are needed, as well as equality-focused toolkits for supervision and monitoring outcomes. The strategy covers patients across the life course, with specific sub-strategies for women and disabled people. They considered human rights with respect to age, education, and socioeconomic status. The strategy is drawn from evidence-based practices and adapted to Dubai’s cultural context. They adopted WHO’s model consisting of two groups: informal community-based care and formal care through the healthcare system. They began implementing mental health services and training providers in two primary care centers and are planning to expand to the remaining centers. The fundamental cross-cutting strategy is empowering patients: “we want them to be active participants in their communities rather than passive recipients of services.” They are also concentrating on health workforce training and development to keep providers updated within the dynamic and challenging health system.

Marlene Montoya is a Native American member of the Navajo Nation tribe, which spans Arizona, New Mexico, Colorado, and Utah. She has been a senior CHW for four years, and is responsible for around 130 of her community’s 800 members. The Navajo Nation Community Health Representative (CHR) program was established in 1968, with budgeting through grants every year. She is one of 99 CHRs across the Navajo Nation, only three of whom are male, and most of whom serve their own rural communities. CHRs serve as effective advocates for their communities because they know the community’s strengths and weaknesses and are already trusted community members. Chronic illnesses such as diabetes and hypertension are prevalent, but mental health is often considered a taboo that is not traditionally spoken of by elders in these communities. Reservations have high rates of unemployment, she said. Men often have to move to towns or out of state to find work. As a result, many experience depression leading to alcoholism. Post-traumatic stress disorder among veterans coming back from war is also common, and there was an epidemic of suicide among young people in recent years. Opioid abuse is now moving into the reservations.

Montoya explained that people with mental illness encountered during home visits are referred to public health nurses who make an appointment to visit the home. Traditional healing for mental health is also offered in some communities through sweat lodges with traditional singing, for example. Managed Care Organizations are able to reimburse some people who provide services, such as the shamans. The Indian Health Service program also provides assistance and some funding. Interns and students often come to reservations to carry out clinical studies or reimburse educational loans, but they typically do not stay long at the reservation, which undermines continuity of care. The New Mexico Department of Health provides training and certification in ten core competencies. Giuseppe Raviola (Harvard Medical School and Partners in Heath, USA) commented that this underscores issues around the non-mental-health tasks of CHWs as well as the definition of mental health itself. He attended a trauma training with the Lakota Sioux Rosebud reservation in South Dakota. The training with CHWs focused on learning about historical trauma, the kinship system in local communities. It is critical to integrate “practice-based evidence,” he said. Screening with the PHQ-9 in these communities would not be the most appropriate first step in a CHW mental health model, for example.

Garmai Cyrus, a registered nurse and a trained licensed mental health clinician, is the mental health coordinator for Partners In Health Liberia. She has ten years of experience working in mental health in both government and NGO settings, including serving as mental health and psychosocial officer during the
response to the Ebola outbreak within one of the biggest Ebola treatment units in Liberia. Cyrus explained that practice-based evidence to convince donors to invest resources in stakeholder engagement comes from the work that they do with their patients in Liberia. This street patient care for the most obvious mental illnesses has changed things in Liberia: “those patients are our voices.” Other programs include World Mental Health Day, in which patients who have been treated and reintegrated back into their communities are asked to provide testimonies for donors and stakeholders. Their evidence comes from patient “success stories” who speak about their own experiences.

In terms of working with a small team and no money, Cyrus said that they have been very frank with people. When working with the government or NGOs in communities, people often are under the impression that there is a plethora of money available when there is not. She emphasized that it is important to be honest and explain to people that it is for their own good. They have tried to include mental health in all departments of the health system, including NCDs, HIV and AIDS, reproductive health, emergency, and primary care. Providers are clearly trained, supervised, and supported in providing care for health in totality, which integrates both physical and mental health.

With respect to engagement, Cyrus said, they manage by doing everything together. They have many community engagement programs, including a community entry program where they meet stakeholders such as superintendents, women’s and men’s groups, students, teachers, and security staff. She added, “...we go there mainly because we want their support. We can’t work in these communities if we don’t get the support of these people. They are the gate keepers, and for us to succeed we have to engage them and let them know what we are going to do...what’s their involvement? How can they support us? We have been successful in doing that.” They work with the coordinating mental health unit at the MoH in Liberia, within which county health teams have mental health departments with clinicians serving as focus persons. In facilities, MoH mental health clinicians work closely on shared activities including care delivery and joint outreach.

Priest and psychologist Eddy Eustache served as the director of psychosocial services at Zanmi Lasante (ZL), Partners In Health in Haiti. After the 2010 earthquake, the Haiti MoH asked PIH ZL to launch a community-based mental health program (funded by Grand Challenges Canada). The project addresses CMDs like depression, epilepsy, psychosis, and child and adolescent mental health by developing curricula and training providers at all levels of the mental health system, including CHWs, teachers, traditional healers, psychologists, social workers, nurses, and physicians.

Eustache explained that engagement from and with the MoH has been a process, beginning with the simple recognition of CHW-based approaches through acceptance to adoption of the model. In 2017, the MoH in Haiti decided to build a system based on the community-based approach. They provided support and training to do so, but despite the mental health unit there is still no mention of mental health. This is unfortunate, but there is a silver lining in that they have now engaged with the MoH and developed the core curricula. Engagement with communities starts from the needs in the community. The social picture in Haiti spans rural and urban people with a polarity between them. “We need now to address the expectations from the major part of population—which is rural—to try to harness the expectations, openness, and spirit of collaboration they have been able to garner among the leaders and CHWs. It is also important not to work in opposition to spiritual leaders.”

Donors are expecting delivery on the promises they funded, thus teams should be mobilized around this objective. First, they need to buy into the model that is being implemented. All stakeholders in the system need to be trained and provided with opportunities to
To convince donors to open their wallets and continue funding initiatives, ask them to see the model that is replacing the failed institutional model that had only two mental health institutions for 11 million people. “The community-based approach is the best answer, and I think we’re on the right track for doing that.”

6.4 WORKING GROUP ON STAKEHOLDER AND COMMUNITY ENGAGEMENT FOR SCALING UP INTERVENTIONS: FIRST SESSION

Reports from the first session of the working group on stakeholder and community engagement for taking interventions to scale were provided by Siham Sikander of the Human Development Research Foundation (Pakistan), Rabih El Chammay of Saint Joseph University and the Beirut National Mental Health Program (Lebanon), and another participant. Sikander opened by summarizing key points made by the group during their discussions around each of the five questions provided.

6.4.1 Identifying potential stakeholders

The first question centered on identifying the potential stakeholders for scaling up mental health programs in LMICs and how their critical feedback can be incorporated into the design and delivery of CHW interventions for CMDs. As a starting point to set the tone, the group sketched some guiding principles for engagement based on empowerment, transparency, and integrity for all stakeholders. In defining potential stakeholders, they tried to be broad, inclusive, and appropriate to local context: stakeholders are people who are affected by or offer support to programs. Under this definition, stakeholders include patients and their families, providers from the public and private sectors, regulators (such as ministries of health), NGOs, and academia. Potential stakeholders also include organizations of people delivering services who can potentially influence policy, contractors from the labor force, and people from the educational sector. He noted that depending upon the specific setting, religious leaders, traditional healers, and faith healers may also be stakeholders and/or serve in CHW roles. For example, pastors in Haiti are recognized leaders in their communities whose influence might be leveraged. Potential private sector partners may also become stakeholders and shape policy, for example, if their interest in investing in hospital-based health services is shifted through effective advocacy toward investing in community-based health services. Sikander said that the group also sought to clarify who CHWs are by sketching some essential and desired criteria. They discussed how CHWs should be from the community in which they work, or at least have some degree of commonality with that community (such as language) to garner trust and establish rapport with community members they serve. Clear selection criteria for CHWs are important for communities as well as for governments and regulators.

6.4.2 Key components of sustaining effective engagement

According to Sikander, the group addressed the next three questions in parallel, discussing issues related to the key components of effective engagement and maintaining effective collaboration with communities as well as with national- and local-level governance, particularly in resource-constrained settings. The group highlighted the importance of “people skills” and understanding the range of stakeholders’ perspectives. They discussed how researchers should learn the language of these particular stakeholders to mitigate the barriers that arise out of communication difficulties. Understanding the stakeholders’ unique perspectives, needs, and drives—both financially and professionally—is critical to facilitate effective advocacy and to generate financing. El Chammay added that it is important to engage stakeholders from day one, with a focus on building and sustaining a
network of stakeholders. A dedicated person should be in place to focus on nationwide stakeholder engagement. Sikander noted that it is also important to find ways to ensure that the engagement process is as effective as possible, such as establishing KPI and quality measurement toolkits from the outset. The group also discussed how to empower potential stakeholders by imbuing them with the sense that they are collaborators, equal partners, and in some cases investigators in the enterprise of community mental health delivery. To the final question—how stakeholder engagement could be used to generate finances for supporting and sustaining collaborative interventions—the group briefly discussed the potential for adapting local government funding, charity-based funding, and corporate social responsibility funding. However, the most sustainable approach is for these types of programs to be budgeted within the national programs, said Sikander. Another potential avenue would be adapting educational fund for health financing.

6.4.3 Levels of stakeholder engagement
A participant commented that the most effective means for engaging and managing large numbers of stakeholders will vary according to the type of stakeholder. Therefore, it is important to categorize stakeholders, for example, according to levels of stakeholder engagement. This type of categorization might begin by merely informing stakeholders at the community level, then move on to consultation, active involvement, collaboration, and empowerment, coupled with efforts to establish new stakeholders with different areas of influence and support. Some stakeholders do not need to be monitored, but simply acknowledged, whereas others will need active management. She suggested that placing stakeholders on a matrix of influence and support, spanning high and low levels, would help guide the engagement process. The participant emphasized that stakeholders need to be inclusive and representative, but she noted that it can be time consuming to identify and engage those particular groups and individuals. Other key elements and guiding principles of stakeholder engagement include clear and transparent communication, with inbuilt integrity and trust, as well as mutual respect. Openness, and flexibility are critical because stakeholder engagement is dynamic and constantly changing, requiring intrinsic flex in the process to adapt to changes on the ground. After using this type of matrix to structure stakeholders and deciding upon the engagement process, implementation is the next step. She described an implementation process that begins with activation, bringing in potential stakeholders and gauging their levels of interest through active listening, understanding their perspectives, and finding areas in which knowledge could effectively be shared in both directions. The next step is to work toward consensus based on that synthesized knowledge, and then to build in reflective opportunities for consideration and innovation. This reflection should shape the next steps—gaining commitment and buy in, decision making, locking down actionable steps, and then setting accountability processes with KPI that have been co-designed through stakeholder engagement.

6.4.4 Discussion
6.4.4.63 Demand-side generation
During the large-group discussion that followed the presentation, Vikram Patel reflected on some experiences with the PRIME program. The focus for the last several years has been simply addressing supply-side issues (e.g., system readiness, training providers, etc.), which has not created a change in the demand for care per population-level surveys. Rather, the overarching objective should be to establish a set of recommendations to achieve the goal of improving effective coverage of evidence-based interventions for depression using CHWs as the front-line providers. As such, the role of CHWs should be to increase
the demand for care: “not only the demand to seek care, but the demand to complete care... it’s one thing to go to someone for help, but it’s altogether another to engage with the intervention.” For example, prior to the shift toward community engagement for HIV/AIDS, antiretroviral therapies were available in many parts of Africa well before there was demand for them. Demand-side generation should be a key element of stakeholder and community engagement going forward, urged Patel.

The second key element is how to engage with governments, funders, and community stakeholders to instill accountability, both in terms of ensuring value for money and in fulfilling commitments to communities by monitoring the extent to which the quality of care they are receiving matches up to their expectations.

El Chammay commented that demand for services is often low in communities not due to stigma around mental health, but due to lack of knowledge and awareness. In such cases, media might become a stakeholder in helping to build awareness among communities through radio, television, or print media. Abebaw Fekadu (Addis Ababa University, Ethiopia) noted that the media can be a stakeholder, but often has its own interests and motivation that may diverge with the intended message. Haifa Madi suggested identifying governors or other community leaders as stakeholders who could be engaged to help increase demand for community health initiatives.

Anne Becker (Harvard Medical School, USA) also commented on the need to increase demand for services, uptake, and commitment to complete. In addition to focusing on managing up, it is also important to focus on engaging with those with lived experience (defined very broadly, to also include people who are collateral members of the social networks of individuals living with mental illness, such as family members). “Only if the care delivery reaches those most marginalized—the worst off—is the system going to be satisfactory,” she said, “We need to find a way to create a system of feeding into planning for the very most marginalized.” Becker noted that the working group discussed how representation can be problematic if it does not encompass the most socially disenfranchised groups, such as women, youth, and those with specific disabilities. Becker noted that the working group also touched upon how to attain a panoramic view and consider mechanisms such as 360-degree feedback. One of the dimensions that is evaluated is how well the CHW is engaged or how deeply engaged in the community, she added.

6.4.6.44 Stakeholder analysis

Haifa Madi returned to the distinction between upstream and downstream stakeholders. Given that stakeholders differ depending on the context, she suggested that stakeholder analysis could be helpful in understanding the division of labor in a particular area, which could be used to assign roles and responsibilities to each stakeholder within a framework of accountability. She also suggested learning from the creation of the global plan of action for noncommunicable diseases space.

Fekadu also shared some of his experiences with PRIME. Given that stakeholders are context-specific, local-level data should be collected to perform the stakeholder analysis. That is, it is important to learn directly from the communities about their best stakeholders to engage and where the services should be implemented locally. He agreed that this engagement requires joint accountability from key stakeholders, including mental health leaders, with platforms in place to ensure accountability.

A participant commented that on occasion, attempts to engage stakeholders has backfired and did not lead to buy in or consensus. She suggested creating guidance on identifying and managing potential risks related to stakeholder engagement through some type of risk analysis. She also suggested establishing a set of generic engagement strategies that could be linked to additional engagement tools that are creative, engaging
mechanisms contingent upon where that stakeholder lies on the matrix. For example, stakeholders who need to be empowered (e.g., people with disabilities or people you want to move into self-advocacy) require different types of tools than those required for managing government agencies. She suggested creating a list of different tools appropriate for various types of stakeholders, in addition to their potential risks.

6.4.4.65 Implementation: good supply drives demand

Noting the inclusion of academia among the stakeholders identified by the working group, Patel asked if it refers to implementation experts or academia more broadly construed. Sikander replied that both are likely to be involved; researchers and evaluators are needed in the mix to evaluate scale-up and to inform research-based questions, for example.

Dan Palazuelos (Harvard Medical School and Partners In Health, USA) remarked that concepts underlying demand and supply span implementation experience and academia. A prevalent concept in the literature, he said, is that community has demand while program implementers have the supply—that is, “we build it and they don’t come, so we have to go and educate them that this a good service and they should take it.” Although the dominant theory related to the concept is that communities do not know that they should want the service and must be taught to want it, he said. However, traditional healers do not have a similar demand problem. Cultural differences is an oft-cited explanation for this, he said, but the reason is that from the consumers’ perspective, traditional healers in those settings provide a better quality service in terms of timeliness, people-centeredness, affordability, and effectiveness. The economic theory that good supply drives demand also holds in implementation science. He noted that Partners In Health has never had a demand problem because the quality of services they provide are the best available. He called for a decision among implementers to choose between two paths: doing what is feasible and cheap, and then inculcating people with the demand for that subpar service; or building a quality service delivery system that will self-generate much of the needed demand. Pamela Collins likened this to the Friendship Bench program, which had huge demand when people learned how it could help. Engaged CHWs were circulating information about the program as one of the problem-solving methods they learned during their training. By virtue of being a practical and effective intervention, it generated its own demand.

Sikander questioned whether the assumption that good supply will drive demand is more applicable in facility-based settings (e.g., Palazuelos’s example from PIH) than in settings where CHWs are embedded in the community. He suggested that in the latter type setting, the method of community engagement may be a stronger driver of demand because people do not have to be taught to come to CHWs in the same sense that they need to be taught to seek facility-based care. For example, across two sites his group launched a system of embedded CHWs who are trained in mental health interventions and have been very well-received by their communities, who perceive them as credible and trustworthy allies who are linked into the existing health systems. “Demand will come with the spread of word-of-mouth that these are good people who solve problems and are there to help,” said Sikander.

6.4.4.66 Engage with existing community structures

Basimene Nyhlema (Partners In Health/Abwenzi Pa Za U moyo, Malawi) highlighted the need to engage with existing community structures because to some extent, CMDs are often normalized in communities and not perceived as a problem per se, because people with CMDs often seem to be functional. Communities may need to be sensitized and educated to understand that that CMDs can escalate to serious problems if left untreated. In Malawi, the government has recommended the formation of community structures that
only exist on paper, due to issues with funding and management. Key stakeholders need to be included in the planning process and be involved in building the capacity of the planned structure, so that they can help raise awareness among the community members and support CHWs. Communities need to be assured that their leaders stand behind the messages that the CHWs disseminate. Singla concurred, suggesting that the community—and particularly male leaders—should be the primary stakeholder. Despite the prevalence of CMDs among men, very few trials related to CMDs have targeted men only. Sikander noted that men have higher rates of completed suicide, yet they are less likely to have depression.

Eugene Kinyanda (London School of Hygiene and Tropical Medicine/Medical Research Council/Uganda Virus Research Institute Mental Health Research Project, Uganda) cautioned that efforts to create demand should take into account cultural context. In his culture, for example, there is no word for depression. Such considerations are hugely important, because people need to understand the basic concepts of CMDs and the services provided by CHWs before demand can be created for the services.

### 6.4.4.67 Community engagement for program sustainability

Lassana M. Jabateh (Partners In Health, Liberia) commented that they are focusing on engaging local communities due to diminished government interest in funding health systems. For example, in many countries in sub-Saharan Africa, there is less funding for health than for security in the national budget. As a result, engaging the local community in delivering services is required to fill some of the gaps created at the national level and to ensure sustainability. In most African countries, CHWs receive small, non-financial incentives from the communities in which they work. For example, CHWs in a farming community may be serving the community at the expense of time spent tending their own farms. To compensate, the community may spend certain days helping at each CHW’s farm so that the CHWs can sustain themselves while continuing to provide community support. In this way, engagement with local communities can directly contribute to promoting the sustainability of a program that provides critical health services.

Anecdotally, Jimena Maza has found from talking with CHWs that the ones most engaged in their work are those who feel they are serving their communities and are appreciated for doing so. Their performance is better because they feel like an integrated part of the community’s structure. She added that this can also strengthen continuity of care, because CHWs develop a relationship with their patients and often seek to add more patients without transferring those they already have.

### 6.5 WORKING GROUP ON STAKEHOLDER AND COMMUNITY ENGAGEMENT FOR SCALING UP INTERVENTIONS: SECOND SESSION

Rabih El Chammay reported back from the second session of the working group on stakeholder and community engagement for scaling up (see Figure 61). Much discussion focused on the components of community engagement across different types of platforms, he said. Mapping two different categories of stakeholders is essential: those who need to be influenced and those who need to be supported. For example, the latter might include a community in need of support in delivering services for CMDs and the former might include the leaders in that community. This type of mapping helps to clarify who needs to be engaged and how. The next task is mapping the phases of stakeholder engagement. The initial step is activation—partnering with the community from the outset to understand their needs and preferences—before moving on to relationship building. During the next step, education, the community educates the implementers about their idioms, traditions, and other cultural
circumstances related to the project; the implementers share ideas about what they could bring in to help the community. This is the point at which the partnership starts in earnest, he said. The third phase, reflection, involves identifying recommended actions and consensus-building toward collaborating and participating around the specific project. Once we have done that we move into different phases. It starts with activation. From day one we need to be partnering with the community. The activation starts by understanding the needs of the community. Once it is understood what they would like us to do, we start creating a relationship. Then we move from the activation to the education. Mutual decision making is the next phase, which involves deciding upon the details of what will be done, how it will be done, and where it will be done. From decision making there is a loop to feedback and evaluation through a support and supervision system. When resources allow, there is a self-corrective process of quality improvement—e.g., reviewing decisions that have been made, or altering the conceptualization of the problem.

Becker suggested that processual assessment is a more apt term than rapid assessment, because it is an iterative, cyclical process of listening and self-correcting that should not be rushed. A participant suggested establishing a set of core competencies for training: e.g., negotiation skills, conflict resolution, and being above the politics. Another component to consider is the moral contract or obligation to which a CHW may be held accountable. This might even be some type of legally binding agreement to hold service providers and community leaders accountable with more teeth than an MOU. El Chammay and Sikander concluded by outlining a set of key takeaways from the second session of the working group.
on stakeholder and community engagement (see Box 11).

During the discussion, a participant remarked that as the mental health burden of disease increases, the focus remains upon charity and goodwill to support communities in overcoming mental health issues. Unlike other types of health issues, countries are not legally bound or pressured by international organizations to put certain health systems into place. He suggested a shift in tactic toward focusing on the costs associated with the increasing burden as well as legally compelling countries, organizations, and stakeholders to uphold their responsibilities to implement policies and programs for mental health. Sikander reflected on how to support CHWs, remarking that “community mobilization is an altogether dedicated, single-track, charismatic, leading-from-the-front kind of approach. It’s time-dependent and it’s a process.” In thinking about support to CHWs, a balance should be struck among activities aimed at lessening the burden, providing CHWs with the skills to treat CMDs, and mobilizing the communities to generate demand. Another participant cautioned against overmedicalization of CMDs and the need to garner high-level support for NGOs and other organizations lacking in authoritative clout.
Box 11. Stakeholder and community engagement: key takeaways

Rabih El Chammay and Siham Sikander underscored a set of key takeaways from the group discussion:

- People in the community may not be aware of specific problems or the disorders, but they are aware of its effect on them. This is a powerful catalyst.
- Identify needs before implementation, to prepare for increased demand for activities in the face of resource constraints.
- Identify the communities’ myths around health and health facilities; understand their stories around it.
- Have face-to-face time with people to build trust on their own terms.
- Put support and supervision structures in place—with inbuilt trust and transparency in the process—to ensure a natural cycle of accountability that does not punish CHWs who are not appropriately supervised.
- Hold community meetings to check in with the community, build relationships, and ensure that they are receiving the services they want and need.
- Train people from the community to become advocates for their own rights.
- CHWs who cannot engage with communities directly should find an ally to attain credibility and trust (e.g., through an NGO that is already established).
- Engage with community leaders and others who create trends and have a sphere of influence.
- CHWs should stay above politics and avoid becoming involved with just one clan or group.
- Learn from case studies (which may or may not be specific to mental health care) about how to create demand in communities.

Source: Harvard Medical School Center for Global Health Delivery-Dubai, Working group on stakeholder and community engagement 2018d.
7 Measurement of Impact

7.1 INTRODUCTION
This chapter provides a summary of the workshop’s content related to measurement of impact, including the review and panel session as well as the output of the dedicated working group’s two meetings. Following report-out presentations from representatives of the working group, the group at large was invited to provide feedback and suggestions to help refine the working group’s deliberations.

The working group was tasked with defining methods for evaluating the impact of scaled up community health worker (CHW) interventions for common mental disorders (CMD). Key areas of consideration related to the task include how to define success, the best metrics available to quantify success, and the most efficient approaches to assess those metrics. Related issues include how to integrate assessment of metrics into routine care to contribute to continuing quality improvement, how impact assessments can be used to sustain and scale up CHW interventions, and how to address the risks to impact assessments.

7.2 MEASUREMENT OF IMPACT: REVIEW PRESENTATION
Mark Jordans, Director of Research and Development for War Child (the Netherlands), set the stage with his presentation about the current landscape of measuring the impact of interventions delivered by CHWs for CMDs. He opened by highlighting some of the conceptual challenges inherent in this enterprise, which are shaped by fundamental questions about how to define CHWs, what they do, the breadth of their impact, and so forth. Although there is much work still to do in defining those concepts and parameters, he said that the existing evidence about the impact of CHWs is promising. He referred to two reviews96 that looked at the effectiveness of interventions by non-specialist/CHWs.97 Across the 65 studies analyzed in the reviews, the clinical outcomes were overall quite positive for depression, post-traumatic stress disorder, alcohol use disorder, and dementia. An increasingly strong evidence base is emerging for psychological interventions or mental health care by CHWs, said Jordans. However, research needs to progress beyond randomized controlled trials to different types of evaluations that measure other types of impacts.

7.2.1 Roadmap to impact
To explore how to scale up evidence-based care and measure its impact, Jordan introduced the model “Roadmap to Impact” (see Figure 71). The model is structured around four axes that bridge the gap in research space between current practice and meaningful evidence-based practice, then onward through the implementation space, which determines whether that evidence-based care will have impact at scale. The model can be used effectively to structure impact evaluation for CHWs, he said.

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96 Singla et al 2017; van Ginneken et al 2013
97 The reviews are described in greater detail in Chapter 4, Section X.X (Singla presentation)
Per the model, the research space requires evidence of the efficacy of interventions. Although much headway has been made on this axis, it is toothless in the absence of evidence demonstrating the relevance of a particular intervention in whatever context it is being implemented. Jordans explained that both the relevance and the efficacy criteria must be met to achieve the goal of meaningful evidence-based care. While these criteria have been met in various well-controlled research studies and projects, the critical challenge lies ahead: in the two axes that delineate the implementation space, feasibility and quality of care. On the quality of care axis, contributing to large-scale impact requires developing evidence-informed standards around quality, competence, and fidelity. Jordans explained, “Evidence-based care will only contribute to impact if it’s implemented by providers who are competent enough, and they implement the intervention with high fidelity.” Standards on the feasibility axis must be attained concurrently with quality of care, in order to ensure that competent providers are providing high-fidelity care that is feasible at scale. In the model, the two standards used to quantify feasibility are coverage (that is, reaching enough people who need care) and the cost associated with that coverage.

7.2.2 Evaluating the pathway to care

Jordans turned to another paradigm for assessing impact at each step of service delivery. He sketched the pathway to care along the following sequence:

- people within the catchment population being identified, to
- people seeking treatment, to
- people attending facilities being detected, to
- people being diagnosed and starting adequate treatment, to
- people benefiting from treatment.

Because the impact of CHWs goes beyond the effectiveness of individual treatments, said Jordans, all steps in the pathway to care should be evaluated. The first step requires evaluating the effectiveness of identifying
people in the catchment population that might require care. The second concerns the effectiveness of the program to get those people to seek care. Evaluating the third step involves looking at the effectiveness of having trained health workers to detect people with mental health needs and the fourth evaluates the effectiveness of health workers in providing adequate care after a person is diagnosed. Only then should the evaluation progress to the effectiveness of care that is being delivered to patients in terms of reduction of symptoms, reduction of impairment of functioning, and so forth.

7.2.3 Multiple evaluation methods

Jordans shifted focus from models and paradigms to concrete examples from the Programme for Improving Mental Health Care (PRIME) consortium. PRIME utilizes multiple evaluation methods and designs to evaluate all the facets of CHW work, as well as to evaluate all the steps in the pathway to care and the roadmap to impact. He described four different evaluation methods used by PRIME to evaluate the implementation of a mental health care plan. The methods were used to evaluate case detection, health worker competencies, community counselors, and routine surveillance.

The first method was a case study used to look at how well the mental health care plan was implemented, using routine monitoring and surveillance data. In the second example, the method employed was a facility survey to evaluate case detection and to determine if the mental health care plan increased the correct diagnosis and initiation of evidence-based treatment. To look at how effectively health workers were able to pick up people who needed mental health services, evaluations were conducted before and after the workers were trained in the mental health care plan, as well as after they provided services. The third method, a cohort study, evaluated whether people treated by the mental health care plan and their families had improved clinical, social, and functional outcomes—that is, to see if people were benefiting at the last mile. Finally, the fourth method was a large representative community survey used to evaluate changes in contact coverage at the population level, which were assessed before and after implementing a district-wide mental health care plan to determine if the plan had reduced the treatment gap.

7.2.4 Evaluating community proactive case detection

The fundamental question, said Jordans, is how to get the right people into care. In Nepal, PRIME has been working on a proactive case-detection tool, the Community Informant Detection Tool (CIDT), to help people in the community to recognize mental health needs and to promote help-seeking behavior. The results of using the CIDT in Nepal were evaluated over three studies. The first study evaluated the accuracy of case detection by people in the community (i.e., female community health volunteers) after one day of CIDT training. The study found that 64% of volunteers had correctly identified cases when compared to clinical evaluation by a psychiatrist (n=195).98 The second study looked at health-seeking after detection in a different sample of 509 people. Of those who were detected, 67% went to a health facility to seek care as a result of the tool; based on self-report, they otherwise would not have sought care.99 The third study evaluated the effectiveness of the CIDT in a district-wide randomized controlled trial, with half of the district randomized to use proactive case-detection approach. Among those in the proactive detection group, there was a 59% increase in mental health service utilization.100

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98 Jordans et al 2015
99 Jordans et al 2017a
100 Jordans et al 2017a
7.2.5 Evaluating interventions by community counselors

Jordans explored the clinical value of adding psychological treatments, delivered by community-based counselors, to primary-care-based mental health services for depression and alcohol use disorder (AUD) through the mental health Gap Action Programme (mhGAP). One such intervention is the Healthy Activity Program (HAP), a behavior activation intervention for people with depression. The effectiveness of the intervention has already been demonstrated in India. Health providers in Nepal have 2-4 minutes to see each patient, which is insufficient to provide psychological treatment. To address this, they deployed community counselors trained to provide HAP. They evaluated the added value of these counselors delivering the intervention (following the mhGAP guidelines) in a small sample; they found moderate effectiveness of providing community counselors to people with depression above and beyond health workers providing care within facilities. According to Jordans, this is a strong argument for adding psychological treatments to the mhGAP package, especially by health workers or counselors who are community-based.

Another study found moderate effectiveness of providing counselor-delivered HAP and Counseling for Alcohol Problems (CAP) in the community for depression. The latter is a brief, counselor-delivered psychological treatment for patients with harmful drinking habits attending routine primary care settings. Counselor-delivered HAP resulted in significantly better outcomes for symptom reduction and improved functioning compared to health workers’ care alone, while counselor-delivered CAP showed a positive but non-significant trend for improved outcomes.

7.2.6 Evaluating competencies of service providers

Service provider competencies are situated on the quality of care axis. After evidence has been established for interventions, competent people are needed to deliver quality care. Jordans explained that the Enhancing Assessment of Common Therapeutic Factors (ENACT) tool is used to measure and assess competencies of service providers. Rather than having a set of competencies for each type of psychological intervention, the ENACT tool measures a set of common competencies that underlie all schools of evidence-based treatment: client and extracontextual factors, therapist qualities, and promotion of hope. In Nepal, they have used ENACT in a study to evaluate changes in health worker competencies using standardized roleplays before and after training. Jordans reported that after trainings of different lengths for CHWs (ranging from 5-20 days), results showed differences in competencies before and after training. In most cases, 75% of minimal competencies were reached after training. There was some variance associated with the length of training, with the biggest jump after 20 days. This touches on the question of the length of training needed to achieve desired competency levels, and what that desired competency level should be: that is, “how good is good enough”? More research will be needed to establish the threshold for competence, added Jordans.

7.2.7 Using indicators for routine monitoring of mental health care

In addition to research studies, another critical component of measurement of impact is to evaluate routine care, Jordans said. In the EMERALD program, they have looked at how to monitor the integration of mental health into primary care in a routine
way. Many LMICs lack indicators in their health management information systems, so through a rigorous process of development, they identified the minimum set of indicators that could be introduced and integrated into primary care settings to measure the routine implementation of mental health services. These include: diagnosis, severity, functioning, treatment, referral, follow up, and payment for consultation. In addition to mental health needs, the indicators can be used to measure other components of effective coverage, such as utilization of care, benefits after receiving care, and financial protection for care (see Figure 31).

**Figure 31. Components of effective coverage**

![Components of effective coverage](image)

**Source:** Jordans, Presentation at Scaling Up Community Health Worker-Delivered interventions for Common Mental Disorders 2018.

Jordans reported on the results of a study aimed at assessing the feasibility and utility of indicators for routine monitoring of mental health care in six LMICs that are part of the EMERALD program. The study assessed the feasibility of introducing those seven indicators, both in terms of performance and of perceived utility. The results were higher than expected, with a completion rate of 74% across the six EMERALD countries at different time points and an accuracy rate of 90% on the seven indicators; 66% also reported positive perceptions of the indicators.106 The next step is looking at the quality of data being gathered. According to Jordans, the results of the study demonstrate a potential new way to measure impact through routine monitoring of systems.

106 Publication currently under review.

### 7.3 PANEL: IMPLEMENTERS’ EXPERIENCES IN MEASUREMENT OF IMPACT

The final panel of the day, moderated by Jordans, featured a panel of experts and implementers who shared their experiences working with front-line organizations to implement community health worker-delivered interventions for CMDs (often as pilots with Ministries of Health). Panelists reflected on how to go about measuring and assessing impact in a way that is efficient and not financially burdensome in places where resources are scarce and prioritizing mental health is difficult. They also considered what to emphasize in approaches to ongoing evaluation of the
impact of existing interventions and identified gaps in current evaluations of the impact of sustained community health worker-delivered interventions for CMDs in LMICs.

Panelists included:

- Alison Schafer (World Health Organization, Switzerland)
- Haifa Madi (Ministry of Health, United Arab Emirates)
- Stephanie Smith (Partners In Health, USA)
- Jafet Arrieta (Institute for Healthcare Improvement, USA/Mexico)
- Eugene Kinyanda (Medical Research Council, Uganda)
- Christian Rusangwa (Partners In Health, Rwanda)
- Carmen Conteras (Partners In Health, Peru)

Alison Schafer works with the World Health Organization on developing a global competency framework, with a particular focus on scaling up psychological interventions. She described her previous work in Kenya with the nongovernmental organization World Vision International, helping to scale up a low-intensity psychological intervention called Problem Management Plus. The project iteratively trained 22 master trainers, 24 trainer trainers, and 280 primary health care staff as trainers. The latter group in turn trained 1600 Problem Management Plus community health volunteers, who ultimately reached 5,000 individuals with common mental health problems in four districts in Kenya over a period of eight months. She shared some of the lessons learned through that experience. In addition to competencies of helpers, it is important to assess the core competencies of the trainers and supervisors. There are huge disparities in impact measurement and the investment of resources in the research, implementation, and scale-up phases. NGOs often do not have the requisite level of academic capacities for measuring impact, she added. For example, the Problem Management Plus intervention in Kenya represents the largest-ever global cohort of psychological intervention recipients, but the data collected was not as rigorously managed as it would have been in a research implementation project. It is also important to consider how and what to measure during implementation, because it will vary widely in different contexts of funding, staffing, and capacity.

In the context of scaling up programs, Schafer suggested establishing the bare minimum that needs to be measured. Data from the Problem Management Plus project in Kenya has now been entered, its quality needs to be determined. The Kenya Ministry of Health had limited capacity and resources for data collection and entry. She explained, “therein lies one of the significant differences between research and implementation: measurement and data.” Schafer recommended identifying a minimal set of indicators, appropriate for different levels of abilities to collect data, as well as the key thresholds or key competencies. She noted programs should still strive to exceed those minimums, but the minimums need to be established to achieve scale. She also suggested creating recommendations about how and what implementation data is collected and used, and what data is necessary for effectively reporting the critical outcomes at implementation and/or scale up. The post-implementation phase is also important to consider, she added. After large numbers of people are trained and organized into community-based groups to deliver a program such as Problem Management Plus, for example, it would be useful to know if workers are still functioning and whether they are still delivering the intervention with fidelity after the NGO has left.

Haifa Madi, of the United Arab Emirates’ Ministry of Health, emphasized that data is critical for measuring impact and results as well as for implementation. She reflected on the implementation of a mental health program in West Bank / Gaza, after a study
conducted with the EU found that over 92% of children in the area had post-traumatic stress symptoms and disorders. This catalyzed efforts to develop a full-fledged mental health program, using schools and primary health care as entry points and platforms for mental health services. Trained counselors and psychologists were put into schools and in primary health care facilities. Rather than establishing a new HMIS to monitor the interventions, they integrated the mental health initiative into the existing systems for schools and primary care. She reported that in the UAE, they are working to develop and implement a package of care to train supervisors and teachers to detect mental health disorders in the classroom. This was motivated by data on global school health showing that large numbers of children and adolescents have suicidal thoughts, with 12.5% of adolescents aged 13-15 years estimated to have attempted suicide. She noted that WHO has developed a package for mental health and its determinants in children and adolescents, which has three components of intervention: a training package for supervisors, life skills training for children and adolescents, and parenting skills for early childhood development.

Madi remarked that a cost-effective HMIS that can measure impact should be integrated into various programs that serve all segments of the population—children, women, adolescents, the elderly, and so forth. The entire process of mental health service intervention needs to be analyzed in terms of process, output, outcome, and impact indicators, she added. Countries are already obliged to report on progress toward SDGs indicators, yet many do not provide that data for monitoring. Madi outlined some additional critical gaps from her perspective. Given that the impact of mental health issues on women and their families is underappreciated, she advised measuring the impact of maternal mental health on children’s quality of life and survival. She noted that the mental health sphere has not matured in its data collection practices to the same extent as maternal and child health or vaccination, for example. Most data available in mental health are national estimates, but that is insufficient for understanding and intervening in the social determinants of mental health. Prevalence data and other disaggregated mental health data at the subnational level are urgently needed. Work is also needed around how to adapt cost-effective interventions that have already been implemented in other countries to other settings. Finally, she warned that the culture of operational research is sorely lacking in primary care and at the community level, which is required to measure impact, quality of care, patients’ perceived quality of care, and so forth.

Stephanie Smith of Partners In Health (PIH, USA) explained that PIH works in ten countries across various levels of the healthcare system in district continuums, with different levels of mental health care ongoing at the different levels. They have begun to implement some low-intensity psychological interventions, including Problem Management Plus in Rwanda and Thinking Healthy in Peru. The implementation of these evidence-based interventions has highlighted the need to develop credible evidence for their efficacy in implementation settings, ideally without requiring a research trial. This relates not only to the competencies of providers, she said, but to the specific standards within. In Rwanda, for example, primary care nurses are delivering interventions under the supervision of psychologists, so they developed a checklist of competencies for the nurses. However, the interpretation of the checklist remains nebulous—it is unclear how many competencies they need to have, or how well they need to deliver care, in order to say that they meet the core competencies.

Smith observed that the denominator is often missing from evaluations, with respect to what is trying to be achieved on a population level. At PIH, they are working on models to help answer fundamental questions that linger in many settings. Key questions include...
the epidemiology of mental health in the catchment area, the types of tasks different people (e.g., people with different levels of depression) should be able to access, and who can deliver care at various levels of the health system.

Jafet Arrieta, of the Institute for Healthcare Improvement (USA/Mexico), called for finding ways to measure impact in the most efficient and least financially burdensome way. To do so, she suggested adopting a true systems approach that is integrated into existing healthcare systems, which is focused on continuous quality improvement. Creating effective measurement systems requires being clear in what we are trying to collectively accomplish at a population level, she added. Shared frameworks and indicators will be needed to accurately measure impact at the population level.

Arrieta urged the group to be intentional about implanting an equity lens into measurement strategies and work to stratify data subnationally to illustrate heterogeneity. To ensure that interventions are sustainable, measures of satisfaction from both the patients’ and the CHWs’ perspectives need to be included in assessment. She also suggested thinking beyond clinical outcomes to find new ways of measuring the impact of interventions, for example, by using DALYs/QALYs/quality of life measures, or measuring productivity decreases due to mental health conditions.

Arrieta also recommended creating systems that allow for the use of balanced, meaningful measures that foster learning and drive improvement, not those employed only for punishment or accountability directed at donors and industry. Measurement systems should focus on impact, but also on implementation indicators such as acceptability, appropriateness, adoption capability, fidelity, cost, and so on. This is particularly important when first introducing an intervention, she noted. The key is to design for scale and sustainability from the outset, rather than funding robust, expensive interventions that will be impossible to scale up. Better collaboration among researchers and implementers will require implementers embedding more research into their work, and researchers carrying out more implementation work. A critical missing piece is the translation of evidence into action and policy, said Arrieta. The responsibility of the researcher should not end at publication, she said; instead, it should extend to influencing decision making to ensure that what has been proven or learned has the potential to have policy-level impact.

Eugene Kinyanda is a psychiatrist working with the Medical Research Council in Uganda, where he has helped to implement a mental health program with a primary focus on integrating HIV and mental health. He explained that the interventions ongoing in Uganda are designed to address severe mental health illnesses; currently, 1% of the health budget is spent on mental health services, of which more than 90% goes to a single mental health hospital. The government had previously been reluctant to fund research on CMDs because they were more interested in looking at specific disorders. However, Kinyanda reported that new funding was received in 2017 for a trial about integrating depression management into HIV care services, which provides opportunities to continue to strengthen engagement with the Ministry and to improve services for CMDs in the country. The trial includes measures of effectiveness (PHQ-9), cost effectiveness, and general effectiveness. The intervention is based on the mental health needs assessment scale (MNHAS), leading to fidelity issues that have arisen because the program had to be translated into the local language, with consequent issues in translating certain cultural concepts. However, the trial setting has helped to resolve those issues.

Christian Rusangwa, of PIH Rwanda, reported that the country’s Ministry of Health is prioritizing the decentralization of primary care and mental health services. To work
toward this goal, two strategies used in HIV were adapted for mental health: mentorship and enhanced supervision of health centers. They are also working to improve the mental health registry because previously, all mental health cases had been coded under the blanket category of psychosis. They have also developed a checklist to assess the competencies of healthcare providers and how they are progressing after training. After creating a database to better understand how patients are getting into care and what conditions are being diagnosed, they found that depression was being underdiagnosed most of the time. To address this, they are using the data collected to develop strategies to improve mental health services. He described an example of how data can directly influence policy. They decentralized mental health services in Rwanda, but all drugs were still being held at the referral hospital. After presenting data to the Ministry of Health showing that increasing numbers of patients were being diagnosed and receiving care at primary healthcare facilities—thus reducing referrals to the hospital—the needed drugs were put into indication lists of the formularies at primary healthcare facilities. Gaps remain on the costing side, said Rusangwa. More data are needed on program costs from the Ministry of Health perspective; the cost perspective of the patient also needs to be better understood. For example, patients’ functionality needs to be measured: that is, the number of days of work a patient misses at different points in care over time and the impact on patient’s families and the community at large. In Rwanda they are using a WHO assessment scale to evaluate how patients are improving while in care and the data collected are informing real-time decisions aimed at improving care.

Carmen Contreras of PIH Peru explained that the organization works closely with health clinics run by the country’s Ministry of Health, with the aim of increasing the quality of interventions in the public sector. In fact, all interventions that they implement are ultimately referred to the public sector. For example, three years ago they started implementing the Protect Home project, a house for women with schizophrenia. Over the past two years, the Ministry of Health has taken full control over the implementation and coordination of this project and it is now situated fully in the public sector, with PIH coordinating the administrative process. She noted that PIH wrote all the guidelines about what happens during implementation of such activities, as well as liaising extensively with the Ministry and providing recommendations about implementing programs in the public sector. As of June 2018, the public sector had already provided funds for five more Protect Homes in Lima. Two other interventions have also been initiated in the last two years, including the Thinking Healthy Program and the Project Management Plus program (which has enrolled more than 3,000 mothers).

To strengthen the interface with CHWs, Contreras suggested first identifying the activities that will have the most impact (e.g., group therapy or accompaniment). She added that the Ministry of Health needs to recognize that the work of CHWs is important, because they are the ones referring patients to the public sector. CHWs would also benefit from increased supervision to improve the fidelity of their activities.

7.4 WORKING GROUP ON MEASUREMENT OF IMPACT: FIRST SESSION

Mark Jordans and Abhijit Nadkarni reported back from the first meeting of the working group on measurement of impact. In considering how to go about measuring results to scale up community mental health services, the group sketched a theory-of-change framework with indicators developed based on evidence and practical experience in the field.

7.4.1 Establishing the goal

The group began with a discussion around how to formulate the overarching goal and conceptual foundation for the entire package.
of community mental health services. The fundamental question at hand was how to determine success, said Jordans, which begs the question of how to measure—and thus define—success in this context. As a starting point, the group suggested that the goal could be “to increase the mental health, wellbeing, and functioning of a community.” He noted that this type of overarching goal should be in line with the theory of change; it may also be worth stating that some elements are above the line of accountability. Even if not all components can be directly attributed to the goal, he said, it is nonetheless important to make such a goal statement explicitly.

7.4.2 Structure of the framework

Next, the group deliberated about the structure of a framework for measuring and scaling up services. Jordans explained that they decided upon a matrix with four columns:

- components of the expanded value chain
- indicators
- best practice and verification
- prioritization

The suggested components of the expanded value chain include: promotion and awareness; prevention; case finding; enrolment; delivery of intervention and treatment; follow-up and reintegration; training; supervision; cost; quality/safety; and linkage and referral. Each category has a process and outcome embedded within it. The group then considered indicators that might be used to monitor and evaluate each of the above components. The potential indicators are listed by component in Table 71.

Jordans reported that due to time constraints, the group was not able to populate the best practice and verification or the prioritization columns. However, for the best practice and verification column of the matrix, the group suggested gathering evidence from research as well as from the experiences of organizations on the ground to determine which indicators can be captured effectively in programs. Prioritizing the indicators will involve looking at feasibility and at what has been demonstrated to work on the ground. Some indicators may ostensibly make sense to include, he added, but they would not be feasible to measure at scale. Ultimately, the prioritized indicators would be used to create the results framework.

Jordans suggested that there may be ways to avoid duplication of work that has already been done in this arena. He noted that the EMERALD Delphi study has already involved experts to help generate HMIS indicators. They created a prioritized list of six indicators that were implemented in project countries to evaluate their feasibility and performance, so some of this work may have already been done. However, those six indicators are focused on the service delivery component in a health system and do not capture the added-value component that is the focus of the working group.
<table>
<thead>
<tr>
<th>Components of Expanded Value Chain</th>
<th>Indicators</th>
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| **Promotion and Awareness**       | • Number of people reached  
|                                   | • Stigma reduction/ attitudes  
|                                   | • Uptake of services (self-referrals)  |
| **Prevention**                    | • Number of sessions in general life skills trainings  
|                                   | • Decrease in prevalence in social determinants of CMDs  
|                                   | • Decrease in prevalence of CMDs  |
| **Case finding**                  | • Number of cases identified  
|                                   | • Number of cases screened  |
| **Enrolment**                     | • Number of cases enrolled  
|                                   | • Uptake in referral service  
|                                   | • Number of cases referred  |
| **Intervention**                  | • Number of intervention sessions  
|                                   | • Number of people received intervention  
|                                   | • Reduction of CMD symptoms  
|                                   | • Number of people completing intervention  
|                                   | • Improved functioning and quality of life  |
| **Follow-up and reintegration**   | • Number of follow up visits  
|                                   | • Number of people with sustained positive outcomes  
|                                   | • Number of people who have had successful reintegration  
|                                   | • Number of people who have receive support in reintegration  |
| **Training**                      | • Increase in skills and competencies  
|                                   | • Number of CHW trained  
|                                   | • Number of CHW who completed training  
|                                   | • Fidelity  |
| **Supervision (including wellbeing of CHWs)** | • Number of supervisory sessions delivered  
|                                       | • Burnout rate reduction  
|                                       | • Job satisfaction  
|                                       | • Sustained competencies and fidelity  |
| **Cost**                          | • Time and resources used per patient screened/treated  
|                                       | • Time and resources used per CHW trained and supervised  
|                                       | • Financial protection (services received)  |
Nadkarni continued by outlining a set of general principles generated by the working group (see Box 11), as well as highlighting some of the points of contention that arose during the group’s discussion. They debated whether to include measurements around decreasing prevalence of the social determinants of CMDs, such as alcohol use and domestic violence. This raised questions about how those social determinants could be measured, and whether it even falls under this mandate to measure those determinants. He asked whether programs should strive to reduce the social determinants of CMD or focus on CMDs after they present themselves.

**Box 11. General principles for measurement of impact (1)**

Nadkarni outlined a set of general principles generated by the working group during their first session:

- Measuring is required to improve quality, although what to measure is up for discussion.
- Measure using technology if possible and if contexts allow it.
- Involve as many stakeholders as possible at as many levels as possible.
- Ensure evidence-based fidelity.
- Use measurement of various indicators to improve the quality of a program, but never use measurement as a punitive measure.

Source: Harvard Medical School Center for Global Health Delivery-Dubai, Working group on measurement of impact 2018c.

Uptake, enrolment, and referral were also points of discussion, because they can be approached in two different ways. One is to simply measure if an effort has been made, Nadkarni said, but he suggested that a more useful metric would probably be to measure if the referral has been completed and whether the patient actually accessed the services to which they were referred. But again, this gives rise to questions about how this could be measured and whether it falls under the current mandate.

Nadkarni remarked that similar issues pertain to improved functioning and quality of life: what is meant by improved functioning, how should it be measured, and what are the indicators? If the plan is to measure how many people who receive treatment are integrated into the workforce, this may not apply in all settings because it is contingent...
upon the overall availability of employment. Follow-up and reintegration as they typically apply to CMDs also require consideration, he said, to determine whether metrics about those indicators applies at all. There also are questions around whether CMDs fall into the categories of disorders that always require monitoring and follow-up, or if follow-up is only warranted if the person is treated, discharged, and then develops another episode of depression (for example).

7.4.3 Discussion
This section provides a summary of the large-group discussion that followed the presentation by the working group on measurement of impact. For a list of indicators that the participants suggested for inclusion in the framework, see Box 72.

7.4.3.68 Establishing frameworks for data collection and analysis
Establishing a data collection plan would be helpful during the indicator prioritization phase, said Arrieta, because it would allow for tracking how well components of the framework are working over time. She also suggested considering the data source, the frequency of data collection, and who will be collecting the data. For example, if different people are tracking different practice units, then a plan for integrating the data may be required. Nadkarni observed that Arrieta’s remarks feed into decisions about how prescriptive the framework should be with respect to components such as the data source and data management. The degree of flexibility baked into the framework is an important consideration, because the utility of the framework may be undermined if it is excessively prescriptive.

If the data is to be used for improvement, noted Arrieta, then it is also important to build in learning systems and to create feedback loops. She observed, “...we’ve been talking about data collection and data going out, but we haven’t talked about data coming back to the implementers, so they can have a better understanding of what is working, how they’re doing, and their outcomes.” Arrieta also cautioned that data tends to be aggregated as work expands to larger scales, but it is important to continue to stratify data to ensure that socio-demographic information (rural, urban, gender, age, etc.) about the populations being served are taken into account.

Anne Becker recommended establishing an analytical framework. Considerations would include whether there should be a universal standard (other than the SDGs) for targets and benchmarking, or whether standards should be contextualized to local settings with a focus on observable improvement. She also suggested assessing how frequently reporting is needed and considering the value of a continuous indicator or integration framework.

7.4.3.69 Working toward a common set of indicators and framework
Alison Schafer commented that establishing a common set of indicators and a common framework has huge potential in terms of improving the reliability of the systematic reviews and in paving the way for measuring the progress of scale-up in real time. Schafer suggested borrowing from the humanitarian sector in setting those common indicators. A common monitoring and evaluation framework has already been developed that is mapped against international guidelines, aimed at establishing consistent measures in the humanitarian mental health sector. She explained that the process involved a minimalist approach in developing a single goal, five outcome statements, and impact indicators for the goal as well as process indicators for the outcomes. Programs are encouraged to pick and choose at least some of the indicators that are appropriate for their program’s country, context, and area of focus (with flexibility for them to still select their

Jordans agreed that such an output would be excellent to strive toward. He noted that the EMERALD Delphi exercise in the primary healthcare setting began with 90 potential indicators that were pared down to six that were tested in the EMERALD countries. It would be interesting to explore additional indicators that would be relevant to CHWs specifically, he added, but this would be more difficult given the lack of data captured by HMIS that underpinned the Delphi exercise.

Regardless of whether the aim of the framework is CHW-specific or to span the entire continuum of care, said Arrieta, both require baseline data, benchmarking, and common operational definitions within a common framework and set of indicators. She noted that benchmarks and indicators can vary widely both between and within countries. El Chammay suggested providing guidance on the harmonization of indicators and collection of data across many platforms. This could help avoid duplication and double recording when different platforms, such as primary care, have dedicated health information systems that are running in parallel with other systems collecting data separately.

### 7.4.3.70 Alignment with global indicators

A participant suggested working to explicitly align indicators or measurements with the SDGs indicators (suicide prevention, for example). Madi agreed about the importance of aligning with the SDG indicators for coverage of interventions, coverage of treatment, the percentage of people that have been rehabilitated, and so on. Madi also recommended refining the list of indicators by identifying the core indicators for each of the various processes. Based upon her experience with health information systems, it is important to be very specific and to pare down the list of both process and program indicators such that they can be aligned closely with the global standards, including those set forth by the SDGs and mhGAP.
Box 12. Additional indicators suggested for consideration

During the large-group discussion, multiple participants made suggestions about indicators that might be considered for inclusion in the framework:

- Disaggregate indicators for vulnerable groups, for example refugees or migrants. [Rabih El Chammay]
- Indicators for training, such as retention of competency to assess how well CHWs retain what they have learned. [Cidna Valentin]
- Indicators for supervision, such as frequency of supervisory sessions. [Cidna Valentin]
- Indicators about role diffusion and task shifting to measure how increasing CHWs’ responsibilities affects burnout, job satisfaction, and retention. [Cidna Valentin]
- A cost indicator specifically for the governance or coordination mechanism to ensure that there is funding to analyze data. [Christian Rusangwa]
- Include indicators for CHW referrals and follow-ups. [Participant]
- Consider integrating quality into case-finding measurement, for example, by taking into account false negatives or false positives, instead of measuring only the proportion of cases identified. [Anne Becker]
- Include information about recurrence and relapse in case-detection measurement. [Participant]

7.4.3.71 Coverage indicators and measurement

Siham Sikander suggested including an indicator or measurement for coverage from a programmatic perspective, such as contact coverage. An example of such an indicator would be the treatment gap or the proportion of a population not covered by an intervention, with the denominator being the assumed prevalence of a particular common mental disorder. Nadkarni noted that the numerator would be the number of cases identified and the denominator would be the number of cases in the community with depression, for example. Those numbers would be available if prevalence statistics exist for a given setting, otherwise a prevalence survey would have to be conducted and expanded to the larger proportion of the population in that setting. However, the working group’s focus was on indicators that would be feasible in most low-resource settings and they decided that such a survey would not be feasible in such settings, so it was not included.

Sikander observed that this approach has a clinical bent, because case finding tends to fall under the auspices of mental health professionals. He suggested shifting to a more programmatic perspective in the language being used, in order to help align thinking about these concepts across sectors—for example, using the broader terminology of “coverage” and “quality” that are used more generally across the board. Jordans agreed about the value of working toward a common language to communicate these efforts across all settings, but he maintained that the current focus should be on collecting the data. He noted that the indicators in and of themselves do not describe how to get coverage—indicators are collected to find out the extent and the quality of coverage.
**Data management in low-resource settings**

Schafer pointed to an emerging paradox. Data collection is critical, but there is often a presumption that a program manager will be responsible for that data. Programs that are scaled up and integrated within government systems (as opposed to being implemented vertically with NGO implementation) will not always have the benefit of a program manager, however. This raises issues about who will be responsible for collecting data, entering it, analyzing it, and using it. While it is important to consider both types of scenarios (government and/or NGO implementation), she added, the reality is that most Ministries of Health (or other government ministries) into which these programs would be integrated will not have the capacity or resources to manage data at this level, or in a sustainable way over time. Further, even ministries that do have the capacity for electronic data management may never actually analyse or use such data, which calls into question the value of collecting data at all. She maintained that it is important to consider the various potential scenarios around data management and utilization in various settings, both with and without program managers.

Jordans responded that the process of prioritizing indicators (as indicated in the group’s matrix) should involve feasibility assessment as well as best practice and verification. Some of the indicators would be embedded within data that are already being collected routinely, and thus would not require any extra resources at the outset. Such indicators could be classified as those that need to be collected to improve services, as opposed to desirable indicators that might be collected based on the feasibility and availability of resources. The same holds for technology, he added. It can make data collection more efficient, but paper-based collection can suffice if resources are not available for electronic collection.

**7.4.3.72 Dynamic metrics**

From her experience in implementation, Hildegarde Mukasakindi observed that metrics need to be dynamic and evolve over time based upon setting-specific needs. She suggested adopting a staged approach to measurement of impact. Integration is a continuous process, she said, especially in the context of mental health interventions. For example, the start-up or pilot phase of a project requires collecting different indicators (e.g., number of cases identified) than the indicators that are needed during the scale-up phase. Raviola said that there are plans underway to test this framework and deeply engage with various sites in Liberia, Mexico, and perhaps Rwanda, and elsewhere. The aim is to integrate community mental health teams and Monitoring and Evaluation and Quality Improvement (MEQ) that are local and cross-site.

**7.4.3.73 Measuring clinical outcomes and functionality**

A participant suggested identifying the clinical improvement outcomes the program is trying to achieve. In the clinical world, the aim is response to treatment (i.e., 50% reduction or asymptomatic remission). In mental health, however, an example of a meaningful outcome would be a person who was extremely depressed becoming a little less depressed. Indicators should be chosen accordingly (e.g., symptom scale, quality of life scale, or self-report), with healthcare workers appropriately trained to be part of the measurement process.

A participant remarked that measuring functionality is a challenge, particularly in the context of the goals of reintegration, social inclusion and quality of life. She suggested referencing the International Classification for Functionality (ICF) program, which includes measures of interpersonal relations, community life, domestic life, and self-care. She suggested that the ICF could set a gold standard measure that sits along the ICD.
7.4.3.74 Prevention and social determinants of community mental health

Madi remarked that the indicators for prevention need further refinement around how to measure the decrease in the prevalence of social determinants of community mental health, as well as how to measure decrease in the prevalence of CMDs. In the noncommunicable disease space, she noted, primary and secondary prevention typically concerns education and awareness to encourage healthcare seeking in a population, as well as creating a conducive environment for treatment. Another participant agreed that decreases in the prevalence of CMDs and their social determinants is challenging and may be beyond the purview of CHWs. However, inequity in access to care could serve as a proxy indicator for social determinants. For example, coverage, access, and availability of interventions and treatments can be very disparate between urban and rural/disadvantaged areas. The reduction in the prevalence of social determinants of CMDs could be embedded in efforts to bridge the gap between existing health inequities in coverage and in outcome, such as morbidity and mortality.

7.4.3.75 Reporting on design

Brandon Kohrt highlighted the need to better document and communicate what is actually being done on the ground in terms of program design, in addition to the focus on reporting outputs and outcomes. He suggested including basic reporting guidance for programs as they develop (e.g., why they chose the model they did) in order to strengthen the rubric about impact.

7.5 WORKING GROUP ON MEASUREMENT OF IMPACT: SECOND SESSION

Stephanie Smith and John Naslund reported back from the second session of the working group on measurement of impact. During their discussion, the group built upon the first session’s work on correlating indicators with the value chain by prioritizing specific areas that would be most essential in assessing what is happening in a system or program. They identified three priority buckets: coverage, quality, and individual-level outcomes. For each category, they generated “must-haves” as well as “nice-to-haves” (given sufficient capacity), with a focus on being specific enough but not prescriptive to the extent that the framework would be irrelevant for some programs. The group’s presentation graphic is provided in Figure 73.
7.5.1 Coverage

In terms of coverage, Smith said, the must-haves include the number of people identified by a CHW and the number of people that are actually enrolled. She noted that enrolled does not mean referred to a facility, but enrolled in the sense that the CHW delivered some kind of intervention, contact, or home visit, for example. It would be nice to have the number of contacts delivered by CHWs. In systems where CHWs deliver therapies, it would also be nice to have the number of people who completed evidence-based therapy.

7.5.2 Quality

Smith summarized the group's work in the domain of improving quality. The percentage of CHWs trained who achieved competence is a must-have, with the definition of competence left up to specific programs to define in their own contexts. It is important to collect data beyond just the number trained, she added, although that number is required for assessing specific process indicators. Another must-have is the number of serious adverse events (e.g., suicide or self-harm) among those enrolled in the intervention or program. She noted that there is much to discuss around the inclusion of adverse events, including the link to SDGs. The nice-to-haves include the percentage of CHWs who retain their competencies over some period of time as well as the percentage of fidelity of delivered care, which could be measured by the number of sessions or some other metric.

7.5.3 Individual-level outcomes

The group focused on individual-level outcomes rather than particular systems, explained Smith. Must-haves were the percentage of people with improved functioning among those enrolled in care;
functioning would be defined by individual programs. The nice-to-haves include the reduction of stigma, the percentage of community health workers reporting high job satisfaction, and the cost of successfully providing care through CHWs (in terms of both time and resources).

### 7.5.4 Process indicators

The group also discussed process indicators and the need to assess programs in an ongoing way. These might include
- number of CHWs trained
- number of CHW activities implemented
- number of sessions delivered
- number of promotion activities
- number who attend activities

### 7.5.5 General guidance

John Naslund provided an overview of some of the general guidance and principles brainstormed by the group. They strove for simplicity, he said, but there are certain elements that are prerequisite for outcome measurement and other important considerations. See Box 13 for the principles they generated during the second session.

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**Box 13. General principles for measurement of impact (2)**

- Disaggregate data for vulnerable groups and consider how to collect data on those that are most at risk and vulnerable.
- Ensure that measures and instruments are culturally feasible, which varies by setting and type of health system.
- Collect outcomes at a systems level, especially for population-level data like suicide rates, to understand whether programs are having an impact.
- Process indicators are a prerequisite for achieving some of the other outcomes.
- Leverage existing data collected routinely in different settings, regardless of whether electronic medical records are in place.
- Establish data collection and management systems as well as reporting frameworks.
- Don’t collect data that is not used and use the data that is collected.

Naslund cautioned that much potentially valuable data falls by the wayside or sits uselessly in a database. There needs to be a system of analyzing, tracking, and reviewing data within a cycle through which it informs the work of CHWs and the systems at large. Responding to comments that data collection is often infeasible and perhaps should not be done at all, Naslund argued for the importance of data and using it properly: “Without collecting data you can never know if you can improve what you’re doing. In any health system anywhere, the minute you start collecting data and presenting outcomes to the people working in those services, you automatically see improvement. Just because it’s hard to collect data doesn’t mean we shouldn’t do it. We should think of ways to make it feasible.” Naslund and Smith discussed how outcome measurement should be part of the systems integration framework. Measurement of impact should be considered from the outset of a project, when systems are designed and outcomes are being set, rather than post hoc.

During the brief discussion that followed the presentation, Rahul Shidhaye suggested situating the framework within a theory of change, with systems thinking and intended outcomes as two sides of the same coin. He also noted that most of the outcomes included
are evaluation outcomes, but implementation outcomes are also important. For example, the fidelity of the delivery of interventions is a key implementation outcome that needs to be measured in order to differentiate system failure from implementation failure. Data should also be analyzed in real time with the assistance of some kind of technical support platform and staff, he added. Naslund responded that outcome measurement should be systemwide to inform each level of the system; considering them separately is not informative, because systems and measurement of impact are inexorably linked.
8 Reflections and ways forward

During the final session of the workshop, the group at large was invited to offer their observations, comments, and suggestions about the workshop proceedings over the three days. Discussions touched upon the content and structure of a potential white paper and/or other publications that might be generated as outputs from the workshop. To conclude the workshop, a panel of expert participants was asked to reflect upon ways forward to scale up programs to implement interventions for common mental disorders (CMD) delivered by community health workers (CHW). Vikram Patel, of Harvard Medical School (USA) and Sangath (India), opened the final session by commending the group for their remarkable efforts over the course of the workshop, which culminated in the working groups sharing the products of their interactions around this extremely important subject. He reminded the group that in his opinion, they are arriving at an inflection point at which significant resources will be made available for implementation of mental health services, especially in the world’s most resource-constrained countries. “As a global health community, we need to be prepared with clear messaging for those that have the resources available,” he implored.

8.1 DISCUSSION

Patel asked the group to highlight any obvious discrepancies, any important elements that may have been missed, and constructive suggestions for moving forward. Participants discussed ways to refine the structure and focus of the guidance, as well exploring potential CHW roles in more detail.

8.1.1 Structure of the guidance

8.1.1.76 Reorganizing by country status

Haifa Madi (Dubai Health Authority, UAE) suggested reorganizing the recommendations by country status, including income level and system structure and stability. She noted the struggle faced in defining what is meant by the term CHW, as well as in defining the scope of community in this context. Noting that the discussion in the workshop has skewed toward low-income countries, she argued that the guidance should be more general. This would make it applicable to all countries that are struggling with mental health care, regardless of income status; many high-income countries do not invest enough resources at the primary health care level. In her opinion, the role of CHWs in low-income countries is completely different from those in high- or middle-income countries. To address this, she suggested categorizing CHWs’ different roles in countries at different income levels as well as CHWs in emergency scenarios. In a country with a fragmented health system and no resources, CHW-delivered mental health care may be the only option. Other health systems will have different needs—for example, in settings with well-distributed primary care, but no integration of mental health care at that level. The scope needs to be clearly defined, including the distinction between focusing on mental illness versus mental health. The latter requires discussions about promotion, prevention, early detection, and then treatment. In an emergency situation, for example, the relevant options for the country facing the emergency are completely different than countries receiving refugees, where systems are more likely to be stable and mental health can be integrated into the existing system.

8.1.1.77 Ensure flexibility in structure

Inka Weissbecker (International Medical Corps, United States), commented about the types of roles and tasks proposed for Stages 0-3. She agreed with the principle of using gradients from less complex to more complex and from low resources to higher resources, but she was concerned that those categories might not be flexible enough to capture
every permutation of factors or combination of available resources (e.g., cases where CHWs do not have enough time but specialized health workers are available). Farah Aqel (Dubai Health Authority, UAE) suggested making the approach more flexible and comprehensive by listing options under each theme, especially for system integration, to account for country-specific systems and contexts.

8.1.178 Suggested framework for integrating workshop themes

Haifa Madi presented a diagram that they use to conceptualize the health system structure in Dubai. They use this structure whenever they initiate a program to present an overview of the project in a condensed way that is easy for all stakeholders to understand; more detailed information is provided in supplemental materials. The vision of the framework she presented is to scale up CHWs to deliver effective and safe care for CMDs. Themes from the five working groups underpin this vision, with associated objectives for each of those themes. Under the objectives are subordinate initiatives, projects, and programs, as well as the requisite enablers. She illustrated using the example of the theme from her working group, stakeholder and community engagement for taking projects to scale. The objective is to strengthen community and stakeholder engagement. Each project or program—for example, developing an effective engagement framework—would have a card with additional context, key performance indicators, timeframes, and quality indicators for measuring impact.

8.1.2 Focus of the guidance and frameworks

Weissbecker also suggested shifting the focus of the framework to CHW tasks, perhaps by organizing them into the boxes of various complexity levels, complemented by basic task boxes linked to psychological interventions. Organizing by tasks would make it immediately clear what resources are required for CHWs to carry out interventions all along the spectrum of complexity. It would also allow tasks to be linked to training or other indicators to measure how successfully the tasks are being done, she added. There may be other options for organizing the structure around these tasks rather than around categories of scenarios, although they may not be mutually exclusive. Patel agreed that reorganizing the continuum for presenting these ideas may be fruitful, be it around context, degrees of sophistication, or complexity of tasks. He noted that the working group on CHW recruitment, training, and supervision presented their work according to tasks, while Weissbecker’s group presented their work structured more along the lines of scenarios or contexts.

Other participants suggested broadening the focus of the framework for integrating mental health. Rabih El Chammay (Saint Joseph University, Beirut and the National Mental Health Program, Lebanon) suggested making recommendations for CHWs in sectors other than mental health as well. In a similar vein, Stephanie Smith (Harvard Medical School and Partners In Health, USA) suggested broadening the target audience not just by sector, but by level. In addition to providing direction to national governance, the recommendations could also provide a more ground-level framework suitable for implementers or program managers, for example. The guidance could be presented in such a way that it is easy for people to find their own particular roles and figure out a way to proceed. Community health should be positioned in the guidance in a way that floats across sectors if the context permits, suggested Siham Sikander (Human Development Research Foundation, Pakistan). Emphasizing the elements of cross-sector collaboration and partnership would be in alignment with the SDGs, he added.

8.1.2.79 Actionable and concrete recommendations

Dan Palazuelos (Harvard Medical School and Partners In Health, USA) was sympathetic
to the call to cast a wider net with the recommendations, but he noted that many other groups (notably WHO) are already taking that tack. He urged the group to be more action-oriented than others have been, by providing specific solutions from a fresh vantage point to gain traction and make the recommendations more easily accessible to those who need them on the ground. Mark Jordans, of King’s College (London) and War Child (Holland) concurred that the recommendations need to be actionable as well as concrete, rather than a list of generic recommendations. With respect to the spectrum suggested by the working group on CHW roles, tasks, and polyvalence, he cautioned that it may be somewhat presumptuous to dictate what a person is able to do at each level. He is more partial to Weissbecker’s suggestion of framing by individual tasks. This might be more actionable and concrete for program personnel to implement, especially if coupled with tools for implementation and measurement.

8.1.2.80 Increasing contact coverage and population-level coverage
At the aggregate level, Patel highlighted the need to find ways to increase contact coverage and effective coverage at the population level.

8.1.2.81 Time estimates
Palazuelos observed that CHW program implementers are very interested in how long each task will take the CHWs, because “time is money.” He suggested creating a chart detailing task options and estimate times to complete them. Even if the guidance is flawed in some ways, it is important to go through that critical first step so that it can be further refined. Even if the guidance is flawed in some ways, it is important to go through that critical first step so that it can be further refined. Abebaw Fedaku (Addis Ababa University, Ethiopia) suggested providing guidance about how to focus on disability, inability to work, and other causes of distress that are relatively universal.

8.1.3 Community health worker roles
8.1.3.82 Psychological treatments delivered by community health workers
Patel flagged the need to more carefully consider the role of CHWs in delivering psychological treatments and precisely how psychological treatments would figure into the scaling up of CHW interventions for CMDs. He cautioned against making recommendations that are contingent upon having requirements in place that are very unlikely to be met in many settings. This would effectively block efforts to scale up the most exciting evidence from the field today, he said. Regarding the role of psychological treatment, Daisy Singla (University of Toronto, Canada) was confident that CHWs can deliver psychological treatments and can do so effectively. However, this needs to be integrated in a way that is scalable and integrated into the system.

8.1.3.83 Training in psychological treatments at all levels
Weissbecker suggested that CHWs might be trained to provide psychological interventions such as Problem Management Plus (PM+), but it will depend upon the structure of the country—e.g., whether there are other community counselors or other health professionals in the setting. Even if there are psychologists in the setting, they might not be trained in PM+ or other types of evidence-based treatment. This will shape decisions about whether to begin implementing such interventions at the CHW level or to begin by strengthening the backbone of the system using those same interventions. Pamela Collins (University of Washington, USA) noted that asking CHWs to carry out assessment will require an additional level of training. She suggested that this and other auxiliary issues should be very clearly specified in the guidance. The tools should be practical guide for a manager on the ground who may have a fleet of CHWs, but has no idea how to start to deploy them.
8.1.3.84 Role of community health workers in community engagement
Patel also suggested further elaborating the roles that CHWs play in community engagement, for example, in issues related to social determinants of mental health. Very often, the curricula for CHW interventions include ways to address issues like a domestic violence, for example. To foster acceptability and to increase demand, he suggested incorporating nonmedical language that employs metaphors and other concepts drawn from the setting-specific common parlance around social determinants.

8.1.3.85 Mental health assessment by community health workers
Patel raised the issues of assessment tasks and the practicalities of mental health assessment by CHWs, which are questions he often fields from policymakers. Specifically, he asked the group to consider the skills that a CHW needs to assess a person’s mental health and then make a decision about what to do with that information. This is a complex undertaking that includes both assessment and a triaging decision of some kind. The latter requires making fine-grained decisions about whether a person needs a low-intensity support intervention or whether the person needs a social work intervention or psychological therapy, for example. He noted that most of the workshop participants are accustomed to assessing and making decisions through research design, often at the expense of grappling with implementation and the practical realities of how CHWs actually carry out their assessments and make these decisions on the ground. Participants with implementation experience may be more attuned to these concerns, he noted.

8.1.3.86 Defining indicators of success
An additional issue related to assessment is how to explicitly define the indicators of success, said Patel. He asked whether a particular measure for assessment should be recommended, such as the PHQ-9 or some similar tool for assessing individual clinical progress.

8.1.3.87 Benefit of additional tasks versus risk of overburdening community health workers
In addition to selecting these common skills and treatment approaches, Sikander noted that there are other skills sets that may warrant inclusion, such as psychosocial determinants, referral, case identification, and responding with psychological first aid. His working group discussed the need to task CHWs with community mobilization and demand mobilization, as well. However, he was worried about the issue of overburdening CHWs with the additional tasks related to those skills—for example, asking them to learn and use an assessment scale to guide triaging and decision making.

8.1.3.88 Refine the concept of specialist
Decisions about whether CHWs should provide psychological interventions without specialist referral will require more consideration to refine the concept of specialist referral, said Weissbecker. CHWs should not be working in a vacuum, she said; CHWs must be supported by someone who knows more about mental health than they do—be it a specialist, psychiatrist, or other trained person—and to whom they can turn to for advice in dealing with complex cases. This type of supervision and consultancy also needs to be available for CHWs in terms of the training and service provision aspects.

8.1.4 More input needed for recommendations
Alison Schafer (World Health Organization, Geneva) was concerned that it might be premature to make definitive recommendations on the basis of the workshop alone. Preparing for the hypothetical large-scale funding injection, she said, would require consulting with related strands of work going on in other spheres who have not yet
been engaged. For example, a massive CHW program is being considered in the context of universal health coverage and related health workforce initiatives. Other professional groups are also doing their own advocacy for a paid workforce on a completely different track than the current workshop’s deliberations. Additionally, ministries (for health and other sectors) and CHWs themselves are absent from the discussion, as are the representatives from large swathes of nongovernmental organizations, other than Partners In Health. She predicted that the iNGO movement will ascend to large-scale influence and should also be part of this discussion. Some of the potential recommendations may need a stronger evidence base, she added. The issues of core competencies or common factors under discussion represent a sliver of an enormous picture. She advised that it is important to be a bit humble in positioning the so-called recommendations, but it should also be done in a way that will inspire people to maintain momentum in furthering the work. Key challenges in getting to consensus and making sound recommendations, she said, are the need for concision and brevity as well as being very careful in positioning the publication. Singla added that the group had yet to clearly define either its vision or its framework for the potential publication or white paper.

8.2 FINAL PANEL

8.2.1 Focus on community health workers

Patel kicked off the panel discussion by agreeing with Schafer that three days of discussion is hardly sufficient to generate definitive recommendations. He suggested that the document could be called a grey paper or discussion paper, rather than a white paper, to better capture the process of building consensus through an iterative, living document with ongoing intellectual engagement. Terminology notwithstanding, the key objective is scaling up interventions for depression, anxiety, trauma-related, and CMDs by CHWs, he reiterated. He agreed that systems clearly need intervention as well and that CHWs do not operate in isolation. However, the focus should be placed squarely on CHWs for this undertaking, he stressed. Proposals to do mental health care at the systems level are very common, but the task at hand is essentially to repackage strategies that already exist, but are framed by CHWs. It is important to take a global-level stance, while also recognizing the differences between contexts in making recommendations. He agreed with Sikander about the danger of going overboard and sinking the ship. He called for maintaining a core agenda delineating the types of interventions CHWs can do for people with CMDs, perhaps including menu-based tasks. If CHWs and a superstructure are in place, it is possible to start working on promotion, prevention, engaging with psychosocial determinants, and so forth.

8.2.2 Sketching a concept- or task-based framework

Patel asked panelist Brandan Kohrt, of George Washington University (USA), the Transcultural Psychosocial Organization (Nepal), and the Carter Center (Liberia) for thoughts on whether the continuum should be framed in term of concepts or in terms of tasks. Kohrt said that to address some of the issues that have been raised, it may be helpful to base the framework on the steps for each individual component. Mapping the components onto the value chains, rather than characterizing an entire system, would provide implementation information on any component. For example, within a given component would be information about the CHW tasks and the relevant implementation procedures. Within this might be steps such as identifying a referral system (as appropriate). He explained that the aim should be to provide guidance on commonly agreed elements set in place to ensure safety, effectiveness, and quality. This would map onto framing the training and appropriate supervision protocol. The same would apply to prevention.
psychological treatments, case finding, social inclusion activities, and so forth. It would also include the supervision methods, indicators and evaluators, as well as the relevant tools. Considerations about cost, compensation, and return on investment could also be included—not necessarily exact numbers, but guidance about what to prepare for and consider. For example, engaging with child and adolescent mental health could have large benefits in terms of return on investment, he added. The advantage of this type of framework is that it moves away from sequential pieces and lays out the options from which people can choose. Providing case studies of how the different pieces of prevention, detection, and intervention (for example) were implemented would also be helpful guidance about the sequence of actions that took place in different real-life, effective, positive-outcome settings. That may be a way of moving away from the stage-based approach, he remarked. Assessment would also fit into this framework. Key tasks would include selecting the appropriate people to involve at each step and determining which tasks could feasibly be carried out by a CHW. Additional decisions include whether to do targeted or selected prevention/promotion and how CHWs could assess that. Psychological interventions offer more leeway than medication-based program, Kohrt added. For example, tools such as local idioms of distress or visual analogue scales that have good sensitivity but poor specificity will not have the same consequences as if a medication-based treatment were being used. Finally, he noted that if CHWs are playing an auxiliary role in a mhGAP program, then the assessment process is not within the bailiwick of a CHW. Rather, the assessment piece would fit into each of the elements in the implementation piece.

Patel wondered about ways to indicate that certain options are relevant across all resource contexts, while others are relevant to low-, middle-, and high-resource settings. Kohrt was concerned that such contextualization may be risky, because mental health care does not follow the same evolutionary trajectory as low income to high income. This could create guidance that is overly prescriptive and potentially not applicable in many contexts. He suggested including guidance specific to certain resource contexts via evidence-based, experience-based vignettes. For example, a vignette could describe a situation whereby a program in a certain resource context successfully used certain pieces, such as credentialing or professionalization issues and here is how they did it. Case studies can also prevent users from immediately dismissing parts of the guidance because they presume it does not apply to countries of their own income level. In general, Kohrt recommended being as universal as possible and then using case studies and vignette scenarios to provide finer-grained, context-specific information.

Jimena Maza (Partners In Health/Companeros En Salud, Chiapas, Mexico) recommended situational analyses within countries, rather than structuring the matrix according to income level, because income level is not necessarily commensurate with the level of existing health and mental health systems. In Mexico, South Africa, and the US, for example, there are significant health inequities. Situational analysis instead of categorization allows for the assessment of contextual factors such as the budget for mental health and how resources are distributed (in terms of quantity, quality, and perhaps geography). The analysis can also be used to map resources across the country. The assumption that low-income countries should invest in CHWs in lieu of developing a system of psychiatrist/psychologist is a flawed one, because those approaches are not mutually exclusive. It is possible to implement a CHW approach that is known to work, while at the same time working with the government to ensure that other resources are being developed.

Laura Murray (Johns Hopkins University Bloomberg School of Public Health, USA) reflected that the discussions over the workshop are central to implementation science. She suggested drawing upon the vast amount of literature in that discipline to draw from existing frameworks that have
already been implemented. On the technology side, Murray suggested creating a **tablet-based resource**, rather than a webpage or document as the output of the workshop as an actionable, accessible, and simple resource for implementers. Technology creates opportunities to move quickly; short assessments and tools could catalyze implementation rather than requiring long assessments that stymie the processes of research and implementation. Patel noted that people are recommending technology in every other field of global health without any evidence, but mental health tends to be overcautious in this respect. He suggested adding a column to the framework for applications and technology related to each of the tasks, even if they are not supported by evidence yet.

Abhijit Nadkarni, of London School of Hygiene and Tropical Medicine and Sangath (India) asked what the unique selling point of the proposed framework and/or publication will be, relative to the huge amount of similar resources that already exist. In his opinion, the document should provide the tools that are suitable for what actually needs to be done. The worry, however, is that the tools might be in a language that people do not use or that they do not understand. A useful document should be short, concise, and useable; it should be presented in a language that people can understand and it should be supplemented with tools that people can use. It must have inherent flexibility that allows it to be used across different contexts. It should have a single, unifying framework that encompasses the themes of all five working groups and upon which all components can be mapped. It would be a mistake to construe these recommendations as the answer to everything, he warned. Instead, it will be the starting point to build upon moving forward.

### 8.2.3 Delivery of psychological treatments by community health workers

Murray highlighted a tension between two viewpoints throughout the workshop: one is to eschew all psychological treatments to streamline the process; the other is to provide more guidance on psychological interventions because people need to know what to do. This tension needs to be resolved, she said, because although people are hungry to understand their options and what they can do to help, most people do not have the requisite expertise. She cautioned against over-recommending a certain option without being clear on the evidence, and she urged the group to be mindful of perceived power dynamics. For example, sometimes people assume that they must do what WHO recommends without considering whether it is actually the best fit. Kohrt reported that WHO is producing “how-to” guidance on implementation of psychological interventions by non-specialists. Nadkarni suggested looking for evidence that demonstrates that a range of psychological interventions of CMDs can be delivered effectively and cost-effectively by non-specialist health workers and CHWs.

### 8.2.4 Engaging with all relevant stakeholders

A participant remarked upon an oscillation between systems-level and operational-level focus; she advocated that a robust engagement and consultation process with all of the appropriate stakeholders should precede the potential publication. Key perspectives are missing from the conversation, she said, including governments and government agencies. She also suggested customizing the output of the workshop into multiple publications, such as proceedings preceded by a policy brief that contextualizes the overarching recommendations into systems to maximize the impact and scalability factors. The white or grey paper could then be published to support guidelines, tools, standards, dropdown menus, and platforms. Governments and funders could provide concurrent feedback that integrates all of the constituent elements. She presented a framework to the group situated at the intersection of disability with mental health and rehabilitation. It illustrates the lived
experience of individuals and beneficiaries starting from the life cycle, taking into consideration the needs of child and adolescents, youth, adults, and older adults within a psychosocial and biosocial model. Key concerns in creating such a framework are ensuring the appropriate perspective, measuring functionality, and adopting the right tools. Building in interventions must take a host of such factors into consideration at the intersecting point of government and NGOs. The healthcare system and care pathway precede these interventions, which requires the provision of standards, guidelines, matrices, quality assurance mechanisms, as well as ensuring prevention, promotion, and intervention mechanisms along these system pathways are up to standards. She explained that elements of reintegration and social inclusion dependent on the level of disability and disenfranchisement. The role of the CHWs should intersect across the elements of the healthcare system in a way that is people-centered, accountable, and affordable. Enablers include the workforce, advocacy, and stakeholder engagement. The ultimate goal, she said, is a sustainable model within which mental health and disability are mainstreamed into the systems that are already in place.

8.3 CONCLUDING REMARKS

Giuseppe Raviola (Partners In Health and Harvard Medical School, USA) offered some concluding remarks. He thanked the workshop participants for their willingness to collaborate in such an incredibly open and productive way over the three days. He thanked the organizers, hosting institutions, and participants for being so generous with their time and energy. For Raviola, the meeting had three purposes. The first was to better prepare site teams to more effectively mobilize CHWs to take care of people with mental disorders. He was confident that at a practical level, the health sites would use what they learned to help people living with CMDs. Given that depression is the leading cause of disability on a global level, CMDs must be addressed directly and swiftly. The second purpose was to move this effort forward, by convening as many people as possible to who engage with NGOs and serve as partners to ministries of health. He was eager to find ways to build upon this spirit of collaboration, perhaps by creating something like a community health compact coalition—but focused on mental health—that could provide a platform for coordination, advocacy, and sharing ideas. The third purpose was to capitalize upon the critical moment for funding into global mental health: to make explicit that the community is ready to seize upon any opportunities that arise. He pledged to be respectful in how the process moves forward and to build upon the momentum that gathered over the course of the workshop in Dubai.
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Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders


## Appendices

### Appendix 1. Mapping skills packages onto existing systems

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<td>Purple</td>
<td>Specialist Case / Referral</td>
<td>Orange</td>
</tr>
<tr>
<td>Triggers-engagement, Education, Support</td>
<td>Blue</td>
<td>Quality/Oversight</td>
<td>Red</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacology</td>
<td>Blue</td>
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</table>
Appendix 2. Developing care pathways for priority conditions
Appendix 3. Workshop Agenda

Scaling Up Health Worker-Interventions for Common Mental Disorders

Objectives for the Workshop:

To synthesize implementation evidence and front-line experiences on community health worker-delivered interventions for common mental disorders, to inform pathways to scale of these interventions, by defining:

1. The roles played by community health workers, and other non-specialized providers, including in community and primary care platforms;
2. The recruitment, training and supervision arrangements of these providers;
3. The systems-level strategies needed for integration of these providers into routine primary care platforms;
4. The use of technology to facilitate these roles and strategies;
5. The evaluation of the scaling up of CHW-delivered interventions (methods and outcomes).

Format:

1. A three-day workshop in Dubai from June 23-25, 2018. This will be a highly interactive working meeting, blending short didactics, panels and breakouts facilitated by global experts and boots-on-the-ground implementers, with group discussion and consensus-building on challenges, best practices and development of a white paper consensus statement.
2. Day 1 of the workshop will be in collaboration with global primary care experts with a focus on synthesizing implementation science and front-line experience on the strategies for scaling up CHW-delivered interventions for the care of CMDs.
3. Day 2 of the workshop will involve group work to articulate the core elements of shared practices and systems design for mental health care delivery by CHW for CMDs.
4. Day 3 will involve the drafting of a white paper consensus statement, and planning of follow up.

Deliverables:

• A White Paper Consensus Statement will summarize the vision and framework for nonspecialist and community-delivered mental health care for CMDs in LMICs generated by workshop participants;
• A Journal Publication, informed by the white paper consensus statement and key outputs of the workshop, will be submitted to an academic journal.
Organization of Meeting and Framework:

Participants have been chosen from a variety of contexts to participate in a lively, structured discussion with the aim of developing a shared framework for delivery of mental health care for CMDs by CHWs (see Appendix 1 for list of participants). The meeting will be a confidential discussion among global experts with intellectual ownership for the workshop outputs to be equally shared. Barriers will be eliminated between “global experts” and boots on the ground implementers.

The meeting will be organized into several panels with working groups, with minimal lectures. Participants will break into working groups which will report to the larger group, to develop operational guidelines for implementation steps in scaling up a community mental health delivery value chain. Participants will themselves choose in which working group they would prefer to participate.

A core assumption for the meeting will be that most participants have already thought a great deal about: challenges to scale from experience; tasks, competencies, and organizational/systems features of community-based models; information technology and data science input to inform roll-out and M&E; and challenges to effective systems engineering and continuous process improvement. The point of the workshop is therefore not to focus too long on review of the basics of any of these, but to work actively toward a shared agreement on the various components of a successful community-based MH model that can be replicated across contexts. Prior to the meeting participants will be asked to sign a form consenting to confidentiality and to agreement to participating in a shared white paper. The confidentiality request is based on the assumption that participants will feel more comfortable speaking openly about challenges they see facing the field of global mental health in actualizing scale. Some pre-readings will be assigned.

Participants will also be asked to choose one working group to join during the meeting. The five working groups will be:

1. CHW Roles, Tasks and Polyvalence
2. CHW Recruitment, Training and Supervision
3. Systems and Strategies for Integration
4. Stakeholder/Community Engagement
5. Measurement of Impact
Meeting Agenda

Location:
- All workshop proceedings will take place at The Center for Global Health Delivery–Dubai located at the Mohammed Bin Rashid Academic Medical Center (MBR-AMC) – Building 14 Dubai Healthcare City, Dubai, United Arab Emirates
- Nearly all participants are staying at Raffles Hotel next to Wafi Mall. Participants are expected to have breakfast at Raffles Hotel before the workshop starts for the day.

Saturday, June 23rd, 2018: Day 1
Day 1- Primary Care, Community Health Workers and Mental Health Care Coordination: Challenges and Solutions

8:00-8:30 am
Registration
MBR-AMC, Case Method Hall – Ground Floor

8:30-9 am
Welcome and introductions
Salmaan Keshavjee Vikram Patel Giuseppe Raviola
MBR-AMC, Case Method Hall – Ground Floor

9-9:30 am
World Health Organization initiatives
Tarun Dua
MBR-AMC, Case Method Hall – Ground Floor

9:30-10 am
Community Health Worker Frameworks: Review
Dan Palazuelos
MBR-AMC, Case Method Hall – Ground Floor

10-10:30 am
Technology and Primary Care Integration: Review
Andy Ellner
MBR-AMC, Case Method Hall – Ground Floor
10-10:45 am
Break

10:45am – 11:45pm
CHW Roles, Tasks and Polyvalence: Review and Panel
Brandon Kohrt & Panel
MBR-AMC, Case Method Hall – Ground Floor

11:45-12:45 pm
CHW Recruitment, Training and Supervision: Review and Panel
Daisy Singla & panel
MBR-AMC, Case Method Hall – Ground Floor

12:45-1:45 pm
Lunch

1:45-2:45 pm
Systems and Strategies for Integration: Review and Panel
Inge Petersen & panel
MBR-AMC, Case Method Hall – Ground Floor

2:45-3 pm
Break

3-4 pm
Stakeholder/ Community Engagement for Taking Interventions to Scale: Review and Panel
Rabih El Chammmay and panel
MBR-AMC, Case Method Hall – Ground Floor

4-5 pm
Measurement of Impact: Review and Panel
Mark Jordans & panel
MBR-AMC, Case Method Hall – Ground Floor

5-5:30 pm
Day 2 planning, selection of working groups
MBR-AMC, Case Method Hall – Ground Floor
7-9 pm
Group dinner (Primary Care & Mental Health)
Raffles Hotel Giza meeting room, 3rd floor

**Sunday, June 24th, 2018: Day 2**

8:30-9 am
Review of Day 1 and finalizing planning for Day 2
TBD
MBR-AMC, Case Method Hall – Ground Floor

9-11 am
Break into 5 Working Groups: Discussions
MBR-AMC, Group study rooms, 2nd floor

11:11:45 am
Presentation and Discussion on CHW Roles, Tasks and Polyvalence
Brandon Kohrt and group
MBR-AMC, Case Method Hall – Ground Floor

11:45-12:30 pm
Presentation and Discussion on CHW recruitment, training and supervision
Daisy Singla and group
MBR-AMC, Case Method Hall – Ground Floor

12:30-1:30 pm
Lunch

1:30-2:15 pm
Presentation and Discussion on Systems and Strategies for Integration
Inge Petersen and group
MBR-AMC, Case Method Hall – Ground Floor

2:15-3 pm
Presentation and Discussion on Stakeholder/Community Engagement
Rabih El Chammay and group
MBR-AMC, Case Method Hall – Ground Floor

3-3:15 pm
Break
3:15-4 pm
Presentation and Discussion on Measurement of Impact
Mark Jordans and group
MBR-AMC, Case Method Hall – Ground Floor

4-4:30 pm
Review of Day 2, and Day 3 planning
TBD
MBR-AMC, Case Method Hall – Ground Floor

4:30-7 pm
Break

7-9 pm
Group Dinner (Mental Health)
Raffles Hotel Azur restaurant, 3rd floor

**Monday, June 25th, 2018: Day 3**

8:30-9 am
Plenary to summarize points from Day 2
TBD
MBR-AMC, Case Method Hall – Ground Floor

9-10 am
Break into Working Groups to revise thematic areas
MBR-AMC, Group study rooms, 2nd floor

10-10:30 am
CHW Roles, Tasks and Polyvalence: Presentation on revision of recommendations, feedback,
TBD
MBR-AMC, Case Method Hall – Ground Floor

10:30-11 am
CHW roles, recruitment, training and supervision: Presentation on revision of recommendations, feedback
TBD
MBR-AMC, Case Method Hall – Ground Floor
11:11:30 am
Systems and strategies for integration: Presentation on revision of recommendations, feedback
TBD
MBR-AMC, Case Method Hall – Ground Floor

11:30-12 am
Stakeholder/Community Engagement Presentation on revision of recommendations, feedback
TBD
MBR-AMC, Case Method Hall – Ground Floor

12-12:30 pm
Measurement of Impact: Presentation on revision of recommendations, feedback
TBD
MBR-AMC, Case Method Hall – Ground Floor

12:30-1:30
Lunch

1:30-3 pm
Discussion on white paper, how to sustain learning collaboration, next steps and wrap up
TBD
MBR-AMC, Case Method Hall – Ground Floor

Plan for departure, dinner on own (vouchers will be provided for those staying at Raffles Hotel)
Participants:

- Azhar Abu-Ali, Dubai Health Authority, UAE
- Saliha Afridi, Lighthouse Arabia Center, UAE
- Hussain Ali Masseh, Community Development Authority, UAE
- Arpita Anand, Dubai UAE
- Farah Aqel, Dubai Health Authority, UAE
- Jafet Arrieta, Harvard Medical School and the Institute for Healthcare Improvement, US
- Anne Becker, Harvard Medical School, US
- Mark Francis Chalamanda, Partners In Health/Abwenzi Pa Za Umoyo, Malawi
- Dixon Chibanda, African Mental Health Research Initiative/Friendship Bench, Zimbabwe
- Sarah Coleman, Partners In Health, US
- Pamela Collins, University of Washington, US
- Carmen Contreras, Partners In Health/Socios En Salud, Peru
- Garmai Cyrus, Partners In Health, Liberia
- Tarun Dua, World Health Organization, Geneva
- Rabih El Chamtmay, Saint Joseph University, Beirut/National Mental Health Program, Lebanon
- Eddy Eustache, Partners In Health/Zanmi Lasante, Haiti
- Abebaw Fekadu, Addis Ababa University, Ethiopia
- Gugu Gigaba, University of KwaZulu-Natal/ Mental Health Integration Programme, South Africa
- Todd Holzman, Harvard Medical School/Partners In Health/Bo-Mphato Litsebeletsong tsa Bophelo, Lesotho
- Sadaf Huq, Building Resources Across Communities (BRAC) International, Bangladesh
- Lassana M. Jabateh, Partners In Health, Liberia
- Mark Jordans, King’s College London, War Child, Holland
- Eugene Kinyanda, London School of Hygiene and Tropical Medicine/Medical Research Council/Uganda Virus Research Institute Mental Health Research Project, Uganda
- Brandon Kohrt, George Washington University/Transcultural Psychosocial Organization, Nepal/Carter Center, Liberia
- Marta Lado, Partners In Health, Sierra Leone
- Fadi Maalouf, American University of Beirut Medical Center, Lebanon
- Haifa Madi, Ministry of Health, UAE
- Jimena Maza, Partners In Health/Companeros En Salud, Chiapas, Mexico
- Marlene Montoya, Partners In Health/COPE, US
- Hildegarde Mukasakindi, University of Global Health Equity/Partners In Health/Inshuti Mu Buzima, Rwanda
- Laura Murray, Johns Hopkins University, Bloomberg School of Public Health, US
- Abhijit Nadkarni, London School of Hygiene and Tropical Medicine/Sangath, India
- Aliya Naheed, Bangladesh
- Sandeep Nanwani, Indonesia
- John Naslund, Harvard Medical School, US

110 Tarun Dua and Alison Schafer are staff members of the World Health Organization. The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions, policy or views of the World Health Organization.
• Melino Ndayizigiye, Partners In Health/Bo-Mphato Litsebeletsong tsa Bophelo, Lesotho
• Basimenye Nhlema, Partners In Health/Abwenzi Pa Za Umoyo, Malawi
• Bethuel Nyachienga, Partners In Health, Liberia
• Dan Palazuelos, Harvard Medical School/Partners In Health, US
• Aneeta Pasha, Interactive Research & Development, Pakistan
• Vikram Patel, Harvard Medical School/Sangath, India
• Gloria Pedersen, George Washington University, US
• Inge Petersen, University of KwaZulu-Natal Centre for Rural Health, School of Nursing and Public Health, South Africa
• Nishat Rahman, Building Resources Across Communities (BRAC) International, Bangladesh
• Giuseppe Raviola, Harvard Medical School/Partners In Health, US
• Alex Riley, science writer, Bristol, UK
• Christian Rusangwa, Partners In Health/Inshuti Mu Buzima, Rwanda
• Alison Schafer, World Health Organization, Geneva
• Rahul Shidhaye, Public Health Foundation of India, New Delhi/Sangath, India
• Siham Sikander, Human Development Research Foundation, Pakistan
• Daisy Singla, University of Toronto, Canada
• Stephanie Smith, Harvard Medical School/Partners In Health, US
• M.A. Subandi, Indonesia
• Archana T Sudhakaran, Tata Trusts, India
• Tri Hayuning Tyas (Nuning), Indonesia
• Cidna Valentin, Partners In Health/Zanmi Lasante, Haiti
• Lena Verdeli, Columbia University Teacher’s College, US
• Inka Weissbecker, International Medical Corps, United States
• Sandra Willis, Government of Dubai, UAE
• Jesse Wilson, Partners In Health, US
• Sheena Wood, Harvard Medical School, US
• Sakila Yesmin, Building Resources Across Communities (BRAC) International, Bangladesh
Appendix 4. Workshop guidance

CHW Roles, Tasks, and Polyvalence
Working Group #1, Facilitator Guidance

**Background Information:** This working group goal is to define the specific tasks and roles that CHWs play in CMD care.

**Sample questions:**
1. What range of roles should CHWs engage in with regard to CMD care?
2. What are the core competencies for CHWs to perform these roles effectively?
3. What ways can we address the issue of CHW polyvalence, i.e. the idea that CHWs should address tasks across medical and social conditions, so that the essential tasks of mental health care delivery for CMDs is addressed in an efficient and effective way?
4. What are the potential risks and barriers to CHWs providing CMD care and how can these be addressed?
5. What are the relative advantages or limitations of generic CHWs be providing CMDs as opposed to mental health specialist CHWs?

CHW Recruitment, Training, and Supervision
Working Group #2, Facilitator Guidance

**Background Information:** This working group goal is to define scalable approaches to recruitment, training and supervision of the delivery of CHW interventions for CMD.

**Sample questions:**
1. How can we train CHWs to deliver CMD interventions in a scalable way, for e.g. reducing the disruption to CHW existing roles and the reliance on mental health professionals?
2. How can we assure quality of CMD care in routine health care services in a scalable way?
3. What are the essential characteristics of CHWs which make them suited to the care for CMDs?
4. What are the potential barriers to effective training and supervision and how can these be addressed?
5. What aspects of health workforce management, wellness and self-care should be addressed in development of a holistic model for CHW-focused care of CMDs?
6. What role can digital platforms play in training and supervision?
Systems and Strategies for Integration  
Working Group #3, Facilitator Guidance

Background Information: This working group goal is to define the strategies on how health care systems can support, enable and sustain the integration of CHW interventions for CMD.

Sample questions:

1. What are the barriers to the integration of CHW interventions for CMD in routine health care, in particular in contexts where primary care is weak or fragmented, and how can these be addressed?
2. How can digital technologies enable integration of these interventions?
3. How would we estimate the per capita number of CHW for integrating CMD care, assuming generic CHW are providing CMD care alongside their other duties?
4. What are the referral pathways needed to ensure ‘stepping up’ and ‘down’ according to patient needs, and what are the strategies to enable these?
5. How can we ensure that mental health is not integrated as a vertical service, or seen as an add-on service?
6. What are the threats to sustaining CHW care for CMDs and how can these be addressed?
7. Systems can be inherently resistant to change. What are strategies for creating “buy-in” when attempting these novel models of care delivery?

Stakeholder and Community Engagement for Taking Interventions To Scale  
Working Group #4, Facilitator Guidance

Background Information: This working group goal is to define the role of community and wider stakeholder engagement in enhancing the effectiveness of CHW interventions for CMD.

Sample questions:

1. Who are the key stakeholders and how do we incorporate critical stakeholder feedback into the design and delivery of CHW interventions for CMD?
2. What are the key components of effective engagement with Ministries of Health, and national and district authorities around implementation of CHW-delivered interventions for CMDs?
3. What are the key components of effective engagement with communities around implementation of CHW-delivered interventions for CMDs?
4. These engagements require tremendous time and commitment. When working with small teams and with limited resources, how might teams be organized and mobilized to keep partners updated and informed, and to maintain effective collaborations with government, community and other stakeholders?
5. How can stakeholder engagement be used to generate finances for supporting and sustaining these interventions?
Measurement of Impact
Working Group #5, Facilitator Guidance

Background Information: This working group goal is to define the methods for evaluating the impact of scaled up CHW interventions for CMD.

Sample questions:
1. How should success be defined? What are the best metrics available to quantify it?
2. What efficient approaches might be used to assess these metrics?
3. How can these be integrated within routine care?
4. How can these contribute to continuing quality improvement?
5. How can these impact assessments be used to sustain and scale up CHW interventions?
6. What are the risks to impact assessments and how can these be addressed?
Appendix 5. Working group participants

Working Group 1: CHW Roles, Tasks, and Polyvalence
Brandon Kohrt (Facilitator)
Garmai Cyrus (Facilitator)
Sheena Wood (Notetaker)
Dixon Chibanda
Sadaf Huq
Mark Chalamanda
Basimene Nhlema
Laura Murray
Christian Rusangwa
Dan Palazuelos
Melino Ndayizigiye
Hildegarde Mukasakindi

Working Group 2: CHW Recruitment, Training, and Supervision
Daisy Singla (Facilitator)
Marta Lado (Facilitator)
Sarah Coleman (Notetaker)
Fadi Maalouf
Nishat Rahman
Alison Schafer
Lena Verdeli
Gloria Pedersen
Arpita Anand
Todd Holzman
Azhar Abu Ali
Carmen Contreras

Working Group 3: Systems and Strategies for Integration
Inge Petersen (Facilitator)
Abbeaw Fekadu (Facilitator)
Sandeep Nanwani (Notetaker)
Jafet Arrieta
Haifa Madi
Archana Sudhakaran
Subandi
Eugene Kinyanda
Rahul Shidhaye
Eddy Eustache
Jimena Maza
Pamela Collins

Working Group 4: Stakeholder/Community Engagement
Rabih El Chammay (Facilitator)
Siham Sikander (Facilitator)
Alex Riley (Notetaker)
Anne Becker
Farah Aqel
Cidna Vatlentin
Hussain Ali Maseeh
Sandra Willis
Lassana Jabateh
Marlene Montoya

Working Group 5: Measurement of Impact
Mark Jordans (Facilitator)
Abhijit Nadkarni (Facilitator)
Jesse Wilson (Notetaker)
Sakila Yesmin
Inka Weissbecker
Bethuel Nyachenga
Stephanie Smith
John Naslund
Aneeta Pasha
Bepi Raviola
Gugu Gigaba
Trihayuning Tyas

Note: some participants took part in working groups other than the ones to which they were assigned.
Appendix 6. Participant biographies

Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders

June 23-25, 2018
Center for Global Health Delivery—Dubai, UAE

Workshop Participants

Primary Care participants (Day 1 only):

Andy Ellner

Andrew L. Ellner, M.D. is Director of the Program in Global Primary Care and Social Change. He is the founding co-director of the Harvard Medical School Center for Primary Care and co-founder and CEO of Firefly Health, a tech-enabled primary care services company. He is also Assistant Professor of Medicine in the Division of Global Health Equity at Brigham and Women’s Hospital and a primary care physician at the Phyllis Jen Center for Primary Care. Dr. Ellner is a graduate of Harvard College and Harvard Medical School. He received an MSc with distinction from the London School of Hygiene and Tropical Medicine and the London School of Economics and completed his internship and residency in the Division of General Medicine Primary Care program at Brigham and Women’s Hospital. Dr. Ellner’s work focuses on the redesign of health service delivery and medical training to incorporate advances in information technology, to hasten the adoption of higher functioning organizational models, and to better address the social determinants of health. He previously worked with the World Health Organization and Clinton HIV/AIDS Initiative on projects to improve health systems in low- and middle-income countries.

Dan Schwarz

Dan Schwarz, MD, MPH is currently an Expert Lead for the Program in Global Primary Care, Associate Director for Primary Care at Ariadne Labs, and Chief Medical Officer for Possible. In his role at Ariadne Labs, among other work, Dr. Schwarz serves on the leadership team of the Primary Healthcare Performance Initiative (PHCPI) in collaboration with the WHO, World Bank Group, Gates Foundation, and R4D. In his role for Possible, Dr. Schwarz has been engaged in over ten years’ worth of work in building a public-private partnership for high-quality primary care in remote areas of Nepal, in collaboration with the Nepali Ministry of Health. Dr. Schwarz completed his undergraduate studies at Vassar College, received his MPH from Harvard School of Public health and his MD from Brown University. He is trained in Internal Medicine and Pediatrics from the Brigham and Women’s Hospital and Boston Children’s Hospital.

Catharine Smith

Catharine Smith is Executive Director of the Harvard Medical School Center for Primary Care. In this role she leads strategic planning and business development and provides oversight for Center operations. She is also responsible for outreach and engagement with collaborators and partners inside and outside Harvard. Prior to joining the Center, Catharine was Vice President of Quality and Education at the Society of Hospital Medicine. Catharine has also worked at Northwestern University in the Department of Family Medicine. Catharine is a former US Fulbright scholar in Uruguay (2002-2003). She holds a Bachelor of Arts from DePaul University and a Master of Arts from the University of Chicago. Catharine’s work focuses on innovative partnerships and collaborative models, sustainable organizational models and team culture.
Mental Health participants (all days):

Azhar Abu-Ali
Dr. Azhar Abu-Ali is currently a senior licensed clinical psychologist at Latifa Hospital under the Dubai Health Authority. She is an active member of the Emirates Child Mental Health Society and the Arabian Child and Adolescent Mental Health Association. Dr. Abu-Ali specializes in working with children, adolescents, and families. Her other specializations include working with trauma survivors such as domestic violence, child abuse, war, medical trauma, grief and loss, and complex trauma. Additionally, Dr. Abu-Ali provides specialized psychotherapy modalities including play, sand, and art therapy. Dr. Abu-Ali has previously served as the Director of Care and Rehabilitation in the Dubai Foundation for Women and Children, worked as a Research Consultant with the World Bank, and served in other capacities such as Clinical Intern Supervisor, and Director of the school-based mental health program for immigrants at the Center for Multicultural Human Services in the United States. Dr. Abu-Ali has received her academic and clinical training in California and Virginia. Dr. Abu-Ali published and participated in comprehensive regional research and theoretical projects focusing on adolescent identity development, child survivors of trauma, treatment efficacy, and multicultural competency. Currently, Dr. Abu-Ali is conducting grant-funded research on caregiving and chronic pediatric illness in the United Arab Emirates. She further specializes in developing and conducting training workshops for professionals in the field of mental health and health care. Recent topics have focused on pediatric psychology and interpersonal childhood trauma. Dr. Abu-Ali is also committed to community mental health awareness and prevention, and has provided community-based workshops. Projects: Leadership of current early childhood initiative under the Dubai Executive Strategy for Mental Health. This initiative addresses infant and maternal mental health.

Hussain Ali Maseeh
Dr. Hussain Ali Maseeh is a clinical psychologist with a private practice. He works as a social development and care expert for the government of Dubai. He established the UAE psychology association in 2003, and is currently working on developing a drug treatment program and developing a juvenile delinquent care program.

Arpita Anand
I have extensive clinical experience of over two decades that includes a counseling practice catering to patients with a range of issues including depression, anxiety, relationship difficulties, grief and bereavement, and work stress, in addition to working with state of the art hospitals across India. I have a keen interest in using this experience for research. This journey began with my contribution to PREMIUM, a project aimed at developing new treatments for Depression and Alcohol Disorders, followed by randomized controlled trials, and dissemination and planning for scale up of the treatments through public health systems. For this project, I led the development of a new treatment for Depression called the Healthy Activity Program based on Behavioural Activation. I assisted in the recruitment and training of lay health workers to deliver the treatment and held overall responsibility for intervention delivery. Following the successful completion of this trial, I was involved in PRIDE project. The goal of PRIDE project is to develop a psychosocial intervention targeting common mental disorders in school going adolescents comprising a combination of self-care and counseling delivered by lay counselors, and to evaluate its effectiveness in reducing symptom severity and improving recovery rates in adolescents with these mental disorders. My expertise includes clinical skills, developing psychological treatments, training, supervision and implementation.

Farah Aqel
A Strategic planning Specialist at Dubai Health Authority (DHA), had Bachelor degree
in Nursing from the University of Jordan in 1992, Master degree in International Health Management and Development from the University of Birmingham in 2005, Diploma in Nursing Middle Management Accredited from Queensland University-Australia, and Diploma in Accounting Department of Finance-Dubai. Joined Department of Health and Medical Services (DOHMS)-Dubai in 1994 as a Staff Nurse and moved through different position and experiences in my career. After 12 years in clinical experience moved to management and planning field until today to participate in many key projects all over the years such as the first Household Survey in the Emirate of Dubai, the first capacity planning project for the healthcare sector in Dubai, Nursing and Quality of Hospital Care in United Arab Emirates research. In addition to Dubai Cancer Centre, Al Jalliah Hospital, Dubai Government Employee Health Insurance Scheme (Enaya), Dubai Model, Dubai Fertility Centre, Nursing Scope of Practice and Professional Licensing, Dubai Government Excellence Program, Code of Conduct and Ethics for Nursing profession in Dubai, developed different Corporate policies and procedures. Developed Mental Health Strategy 2017-2021 in collaboration with subject matter expert; the first mental health strategy in the Emirate of Dubai. Participated in different specialized strategies such as; Knowledge Management Strategy, Health Promotion Strategy and Human Resources Strategy, and Adult Health Strategy. Conducted a research on User Fees in Health Services: policy and practice in the United Arab Emirates. It was first study ever done in gulf area to measure the impact of user fees on efficiency, effectiveness and equity of healthcare services. The first Emirati woman who won the Feigenbaum Leadership Excellence Award in 2009 Under the category of Raising Star.


Jafet Arrieta

Jafet Arrieta currently serves as Director and Improvement Advisor for the Institute for Healthcare Improvement (IHI). She supports domestic and international partners in the development and implementation of large-scale quality improvement projects, teaches quality improvement methods and provides coaching and support to leaders, managers and team members throughout the implementation of their projects. Jafet also serves as Health and Policy Advisor for the Mental Health Department at Partners In Health (PIH). Jafet has extensive experience in operational, oversight, management and leadership roles within the areas of public health, quality improvement and health systems strengthening across different low-, middle-, and high-resource settings. Jafet has previously served as Improvement Advisor for the Latin American Consortium for Innovation, Quality and Safety in Healthcare (CLICSS) leading the implementation of two multi-country quality improvement collaboratives aimed at reducing the incidence of healthcare-associated infections in Latin America, and as Director of Operations for PIH Mexico, helping establish a public-private partnership and leading the execution of a health system strengthening strategy to improve access to high-quality care in one of the most underserved regions of Mexico. Jafet is a third-year student in the Harvard Chan School of Public Health Doctor of Public Health program, and holds a medical degree from Tecnologico de Monterrey School of Medicine, and a Master of Medical Sciences in Global Health Delivery.

http://www.ihi.org/regions/LatinAmerica/Pages/Team.aspx

Anne Becker

Anne E. Becker, MD, PhD, SM is the Maude and Lillian Presley Professor of Global Health and Social Medicine at Harvard Medical School (HMS) and is founding and past Director of the Eating Disorders Clinical and Research Program at Massachusetts General Hospital. An anthropologist and psychiatrist, her
areas of research focus include the social and cultural mediation of presentation and risk for eating disorders, social barriers to care for mental health disorders, and school-based mental health promotion. She has led investigations of the impact of rapid social transition on eating pathology, suicide, and other youth health risk behaviors in the small-scale indigenous iTaukei population of Fiji and has served as co-PI on school-based mental health interventions in Haiti and Lebanon. Dr. Becker is co-editor of a forthcoming book on global mental health training (Routledge). She is former co editor-in-chief of Culture, Medicine and Psychiatry, former associate editor of the International Journal of Eating Disorders, past president of the Academy for Eating Disorders, and served as a member of the American Psychiatry Association’s DSM-5 Eating Disorders Work Group. Dr. Becker served as vice chair of the HMS Department of Global Health and Social Medicine from 2009-2016 and is also past director of the HMS MD-PhD Social Sciences program. She received the inaugural Barbara J. McNeil Faculty Award for Exceptional Institutional Service to HMS in 2014, the 2013 Price Family Award for Research Excellence from the National Eating Disorders Association, and the 2018 Leadership Award in Research from the Academy for Eating Disorders.

Mark Francis Chalamanda

Mark Chalamanda was born on August 8th, 1990 in Blantyre, Malawi. He received a diploma in clinical medicine at Malawi Adventist University in 2011 and a BSc in Clinical Medicine-Mental Health at Saint John of God College of Health Sciences in 2016. In 2011, he joined Zomba Central Hospital as an Intern Clinical Officer and upon completion of internship, he worked in the Obstetrics and Gynaecology department. In 2016 upon completion of his BSc in Clinical Medicine-Mental Health, he joined Saint John of God Hospitaller Services in Mzuzu Malawi where he worked as a Mental Health Clinical Officer and a part time lecturer. He resigned from St. John of God and joined Partners In Health on December 1st 2016. Since then, Mark has worked with Partners In Health as a Mental Health/Psychiatric Clinical Officer. At Malawi Partners In Health, Mark is responsible for all work/activities relating to mental health including: offering Mental Health training and supervision to other health workers, attending to unstable mentally ill and epileptic patients at Mental Health clinic, attending to stable mentally ill and epileptic patients enrolled in the integrated chronic care clinic plus other clients presenting with other non-communicable diseases as well as follow up of patients on ARV’s. Mark and other mental health workers also visits some patients who are reluctant to come to the health facility in their homes. At Malawi PIH, Mark’s efforts have led to mentally ill and epileptic’s quick recovery and proper documentation of mental health and epileptic MasterCards. He has also assisted in keeping Neno hospital premises free of mentally ill clients by launching a campaign of apprehending mentally ill clients and referring them to a Mental Hospital.

Dixon Chibanda

Dixon Chibanda is an associate professor in psychiatry with the Research Support Centre in Harare, Zimbabwe. He is director of the African Mental health Research Initiative funded by the Wellcome Trust and the African Academy of Sciences. He is principle investigator on several research projects that explore the use of task-shifting to narrow the treatment gap for mental, neurological and substance use disorders. He developed the Friendship Bench programme, a low-intensity task-shifting intervention for common mental disorders delivered by community grandmothers, which has been scaled up in Zimbabwe and successfully introduced in a number of Countries.

www.friendshipbenchzimbabwe.org https://amari-africa.org

Sarah Coleman

As of July 2018, Sarah Coleman will be the Program Officer for the Cross-Site Mental Health Team at Partners In Health (PIH), an international non-profit dedicated to health
system strengthening in Haiti, Rwanda, Liberia, Lesotho, Malawi, Mexico, Peru, Sierra Leone and the Navajo Nation. Sarah has been on the Mental Health Team since June 2015, helping to provide project management and technical support to mental health service development across all PIH sites. In particular, Sarah has overseen various training and curriculum development efforts, knowledge sharing between sites, and special projects. Prior to joining PIH, Sarah worked at Massachusetts General Hospital in the Benson-Henry Institute of Mind-Body Medicine and interned at the World Health Organization. She received her Masters of Public Health at Boston University in Social/Behavioral Sciences and Health Policy/Management.

https://pih.org/programs/mental-health
http://www.mhinnovation.net/organisations/partners-health

**Pamela Collins**

Dr. Pamela Collins is a psychiatrist and mixed methods researcher with more than 20 years of experience in the field of global mental health. She is Professor of Psychiatry and Behavioral Sciences and Professor of Global Health at the University of Washington, where she directs the Global Mental Health Program. Prior to her current role she directed the Office for Research on Disparities & Global Mental Health and the Office of Rural Mental Health Research at the National Institute of Mental Health (NIMH) (USA). While at NIMH Dr. Collins launched the Grand Challenges in Global Mental Health initiative and established a program of global mental health services and implementation science research in low- and middle-income countries. She was an editor of the 2011 Lancet series on Global Mental Health, editor of the 2013 PLoS Medicine Policy Forum series on integrating mental health into diverse platforms of care, and co-lead of the NIMH-PEPFAR initiative on mental health and HIV. Dr. Collins currently serves as a commissioner for the Lancet Commission on Global Mental Health. Dr. Collins’ research has focused on social stigma related to mental illness and its relationship to risky behaviors; the intersections of HIV prevention, care, and treatment and the mental health needs of diverse groups US as well as diverse groups in Latin America and Sub-Saharan Africa; and she is developing new research on adolescent mental health and women’s mental health. She obtained her M.D. from Cornell University Medical College and a Master of Public Health from Columbia University’s Mailman School of Public Health. She completed residency training in psychiatry at Columbia University, postdoctoral fellowship training at Columbia University and Harvard Medical School, and joined the faculty of Columbia University, Department of Epidemiology, Mailman School of Public Health and Department of Psychiatry, College of Physicians and Surgeons.

**Carmen Contreras**

I graduated in psychology and have an Adolescent Health Diploma with a major in Sexual and Reproductive Health, as well as a Masters in Public Health. I possess skills to lead and develop research projects with versatility, ingenuity, a strong work ethic, and a deep-rooted passion for the health of vulnerable populations. At the beginning of my career, I devoted myself to the study of families of hospitalized children and adolescents whose mothers were. Then I contributed to research on prevention of adolescent drug abuse, prevention of domestic violence, and development of mental health education materials with the Ministry of Health. For 15 years I have been working at Partners In Health (SES), coordinating research to understand and improve the clinical conditions of the population affected by tuberculosis (TB). Over the past two years, I have been participating in the Community Advisory Committee of SES, which convenes representatives of the community to discuss the various TB protocols and make recommendations from a community perspective. I am also a member of the Community Advisory Committee of Inquiry (Community Research Advisors Group - CRAG) Consortium for Clinical Trials.
Scaling Up Community Health Worker-Delivered Interventions for Common Mental Disorders

of TB (Tuberculosis Trials Consortium - TBTC) of the Center for Control and Prevention (Centers for Disease Control and Prevention - CDC), which includes representatives from across five continents and was established to increase the value and impact of TB research and interventions for the benefit of affected communities. I have participated in and overseen the implementation of various initiatives involving professional field staff and community health workers related to TB, Chronic Diseases, Mental Health, and Maternal and Child health. I have leveraged professional and non-professional resources to reach ambitious goals in promoting community health. Projects: Thinking healthy. Perinatal depression. TB and depression. Domestic Violence

Garmai Cyrus

My name is Garmai A. Cyrus. I am a Registered Nurse and a trained licensed Mental Health Clinician. I was trained by Medecins Du Monde in both community and hospital psychiatry, later went to Uganda with the Peter C. Alderman Foundation for two months training and ten months in Liberia for psychiatry care in the hospital and community setting and lastly, the Carter Center Post-Basic Mental Health Training for six months. Experience wise, I have been through a lot of training in mental health including ToT for mhGAP and Case Management and other mental health related cases within communities. I am ten years now in the service to mental health working from government and now in the NGO setting. I also have experience working in the Ebola outbreak within one of the biggest ETUs in Liberia that was run by the International Medical Corps as a mental health and psychosocial officer. Currently I work as the mental health coordinator for Partners In Health Liberia.

Subandi Deran

Subandi is a professor of clinical psychology at Faculty of Psychology, Gadjah Mada University. He received a Bachelor degree in Psychology from Gadjah Mada University, Indonesia; Master degree from Department of Social Sciences, Queensland University of Technology, Australia; and received his PhD from Department of Psychiatry, the University of Adelaide, Australia. His research interest is in the area of socio cultural and spiritual aspects of mental health, early psychosis and mental health system. He is the recipient of Freeman Fellowship (1997-1998) and Forgaty Fellowship (2009) at Department of Global Health and Social Medicine, Harvard Medical School. In the last five years he has been working on strengthening mental health services in primary health center, in Yogyakarta, Indonesia in collaboration with Prof. Byron and Mary-Jo Good of Harvard Medical School. The overall goal of this program is to provide a better mental health services in primary health center setting, despite the problem of treatment gap in Indonesia. The first project was funded by USAID from 2012 to 2015. In this project the research team developed five different mental health programs in different primary health center, including training for primary health center staffs, training for mental health cadre (community worker), training for family members, evaluation of free ‘pasung’ (physical restraint) program and development of back referral system to ensure the continuity of care. The second project (2016-2018) funded by Harvard Medical School’s Center for Global Health Delivery -- Dubai, tried to integrate all five programs and piloted in five primary health centers and developed an integrated mental health model. The next project (2019-2020) will be the scaling up of this model in one district within the province of Yogyakarta.

Tarun Dua

I am working as a Programme Manager in the Department of Mental Health and Substance Abuse at World Health Organization Headquarters. I lead the implementation of mental health Gap Action Programme (mhGAP) and am also the focal point for brain health in the organization. I provide programmatic support to the monitoring of Comprehensive Mental Health Action Plan. I was one of the editors for the third edition of the Disease Control Priorities in Developing
Countries volume on mental, neurological and substance use disorders.

**Rabih El Chammay**

Dr. Rabih El Chammay is a psychiatrist and currently the head of the National Mental Health Programme at the Ministry of Public Health in Lebanon. After founding the programme, he led the development of the first National Mental Health and Substance Use Strategy 2015-2020 aiming at reforming the Mental Health System in Lebanon toward community-based mental health services inline with Human rights and latest evidence that is currently under implementation. He is a member of the Department of Psychiatry at the faculty of Medicine at Saint Joseph University in Beirut. He has been working in Public mental health, Refugee mental health and health system strengthening for more than 10 years. He has been working on these topics in the MENA region as well as on the international level with various agencies such as WHO, UNHCR, UNICEF, IMC and many other NGOs. Mental Health Programme: [http://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program](http://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program)

**Eddy Eustache**

Priest and psychologist, I have been serving in Zanmi Lasante (Partners In Health in Haiti) as the director of the Psychosocial Services from 2005 to 2010. After the 2010 earthquake along with PIH ZL and upon the request from MSPP (Haiti MoH), ZL launched a Community-based Mental Health program thanks to the funding provided by Grand Challenges Canada. Thanks to this project, we addressed main mental conditions like depression, epilepsy, psychosis and Child and Adolescent Mental Health. As a team we prepared curricula for each of these conditions and we trained all the layers of intervention in the Mental health System. From the CHW, teachers, Traditional Healers, Psychologists, Social Workers, Nurses and Physicians. Parallely I received a training in acupuncture related to Trauma and later on I got a certificate as an acudetox specialist. I am currently a PH.D. candidate in Clinical Psychology. I am helping in the Education Team at Mirebalais University Hospital in raising awareness among the Residents about Rural Anthropology. I continue to help in Wellness and mental Health promotion for them.

**Abebaw Fekadu**

Abe is a Clinical Professor of Global Mental Health and Head of the World Bank Africa Centre of Excellence in Therapeutic Discovery (CDT-Africa) at Addis Ababa University in Ethiopia. Abe is also an African Research Leader of the Medical Research Council/DFID, UK and fellow of the Ethiopian Academy of Sciences. He graduated in Medicine from Addis Ababa University and trained in Clinical Psychiatry in Cardiff and at the Maudsley (UK). He has obtained a certificate in clinical psychopharmacology (British Association for Psychopharmacology, UK), MSc degree (Cardiff University) and PhD (Umea University). His research interests are in clinical trials, complex interventions, mood disorders and knowledge translation.

[www.cdt-africa.org](http://www.cdt-africa.org)

**Gugu Gigaba**

Ms Gugu Gigaba is a Clinical Psychologist by profession and completed her postgraduate studies at University of KwaZulu-Natal (UKZN-Howard). Her research and academic interests have predominantly been on issues around identity, African psychology, sexuality, youth risk sexual behaviors, and community psychology. She is currently the Programme Manager for the Mental Health Integration Programme (MhINT) at the Centre for Rural Health in UKZN.

**Todd Holzman**

Todd F. Holzman, MD is a child and adult psychiatrist in private practice in Cambridge, Massachusetts. From 1973-2016 he was at Harvard Vanguard Medical Associates, where he was also medical psychiatrist in oncology, and consultation/liaison psychiatrist at Brigham and Women’s Hospital. A member of the faculty of Harvard Medical School,
he was Chief Psychiatrist for Disaster Services in the Departments of Mental and Public Health for the Commonwealth of Massachusetts and Chair of Disaster Mental Health and Disaster Services for the Massachusetts Bay Chapter of the American Red Cross. He volunteered for Physicians for Human Rights in Kosovo immediately before the NATO military involvement there to monitor violations of medical neutrality and human rights. He is Past President of the Massachusetts Psychiatric Society for 2008-2009, and co-chair of its Disaster Readiness Committee. Dr. Holzman volunteered in southern India after the Asian tsunami, working on a rehabilitation program for survivors of torture and human rights violations. With the American Jewish World Service, he volunteered in South Africa, Ghana, and Kenya on HIV-AIDS education, prevention, and orphan programs, Northern Uganda reintegrating former child soldiers. He participated in typhoon relief, Tapaz, Panay Island, Philippines, Project Hope, MGH Global Health. Dr. Holzman conducted Medical Psychiatry Training, Consultation at the Partners In Health/Ministry of Health Botshabelo Hospital for MDR TB/HIV, Maseru, Lesotho and the District Hospital, Moehales Hoek, Lesotho, Southern Africa. Dr. Holzman lectures nationally and internationally. He is a contributor to Hidden Impact, disaster psychiatry for medical personnel and the APA Textbook of Disaster Psychiatry. A Distinguished Life Fellow of the American Psychiatric Association (APA), in 2006 Dr. Holzman was awarded the APA’s Bruno Lima Award in Disaster Psychiatry, in 2013 the MPS Presidential Award for Disaster Training and Response to the Boston Marathon Bombing, 2013 President’s Volunteer Service Award, Barak Obama, The White House, Washington, D.C.

Sadaf Huq
I work as a Program Specialist for Early Childhood Development at BRAC Institute of Educational Development in Bangladesh and as a Team Coordinator for BRAC Child Protection for the Humanitarian Crisis Management program. My major areas of interest include; Learning through Play, Play in Fragile Setting, Child Development and Child Protection. My current professional expertise is in Play-based Curriculum Development for children and adolescents, designing training modules on Child Protection & Mental Health for front-line workers on humanitarian issues, also my previous experiences include working as an Early Years Practitioner with children aged between 3-11 years old in a UK based childcare company.

Lassana Jabateh
Lassana M. Jabateh, Director, Community Health Program - Partners In Health, Liberia. 2002 Diploma as a Physician Assistant - Tubman National Institute of Medical Arts, Monrovia - Liberia. I have over ten years’ experience in an in depth understanding of humanitarian work and years of field experience in managing and implementing health programs in crisis mitigation, recovery, transitional and post-conflict in many outstanding positions including Team leader, trainer, Field Medical Coordinator, Health Program Consultant, Senior PHC Coordinator, Health Program Coordinator and Emergency Program Manager in the implementation of health and nutritional services at the facility and community level. Currently, as a community Health Program Director, I have the oversight of the Community Health Worker programmatic work, collaborating with our partner organizations and Ministry of Health to manage the daily activities of Community Health Team with the following responsibilities:
- Support and supervise directly the County Community Health Specialists who are overseeing implementation of the community health worker network in two counties. This support will mainly focus on strategic planning, programmatic implementation supervision and oversight, general coordination, communication, finance and administration.
- Review and analyze CHW programs’ reports on program performance metrics, status
of activities as compared to work plan, and actual spending as compared to budget in order to anticipate, identify, and address potential challenges.

- Support program’s engagement with key partners, donors, and government partners on all administration, management, and finance issues.
- Assist CHW programs in preparing, writing and editing reports; help prepare abstracts and manuscript submissions to professional journals.
- Support integration of the CHW programs and cross-cutting programs, helping to ensure organizational community health priorities and projects steadily move forward.

I have supported the MoH in the revision of the National Community Health Policy and Strategic plans focusing on providing preventive and curative services for more than 21% of the Liberian population living outside 5km away from the nearest health facility.

**Mark Jordans**

Mark Jordans, PhD, child psychologist, is professor at the University of Amsterdam and works as Director of Research & Development for the NGO War Child in the Netherlands. He is a reader, child and adolescent mental health in humanitarian settings at the Center for Global Mental Health, King’s College London. His work focuses on the development, implementation and evaluation of psychosocial and mental health care systems in low and middle income countries, especially for children in adversities and in fragile states. Dr. Jordans is the founder and Senior Technical Advisor of TPO Nepal, a leading mental health NGO in Nepal, where he worked between 1999 and 2011.

**Eugene Kinyanda**

Eugene Kinyanda MBChB, M.Med (Psy), PhD, is a Programme Track- Leader and Head of the Mental Health Project at the MRC/UVRI & LSHTM Uganda Research Unit. He is a Senior Wellcome Trust Fellow (2017-2021) and has previously held a Senior EDCTP Fellowship (2011-2013) and an MRC/DFID African Leadership Award (2014-2016). Over the last 10 years at the MRC/UVRI & LSHTM, Eugene has undertaken research into the psychiatric complications of HIV/AIDS among adults, children and adolescents and older persons looking specifically at the epidemiology of psychiatric disorders (PD) in HIV/AIDS and its impact on clinical, behavioural and social outcomes. He has also undertaken studies into the HIV risk among war affected populations and more recently among persons living with severe mental illness. Through the Wellcome Trust Fellowship, Eugene is developing and evaluating a model for the integration of depression management into adult HIV care in Uganda. His other research interests include the epidemiology of psychiatric disorders in both war affected and non-war affected communities in Africa and suicidology. He has 72 peer reviewed publications to his name.

https://wellcome.ac.uk/what-we-do/case-studies/eugene-kinyanda

**Brandon Kohrt**

Brandon Kohrt, MD, PhD, an anthropologist and psychiatrist, holds the Charles and Sonia Akman Professorship in Global Psychiatry at George Washington University, where he is Associate Professor of Psychiatry and Global Health and Director of the Division of Global Mental Health. Dr. Kohrt has worked with populations affected by war and political violence, disasters, and other forms of adversity in Nepal, Haiti, Liberia, Nigeria, Uganda, Ethiopia, South Africa, Brazil, and Mongolia. Since 2006, he has served as technical advisor to Transcultural Psychosocial Organization (TPO) Nepal where he worked to develop and implement mental health and psychosocial support programs for former child soldiers and earthquake survivors. Since 2010, Dr. Kohrt has worked with The Carter Center Mental Health Program in Liberia, where he designed anti-stigma programs to increase utilization of mental health services.
Dr. Kohrt serves as the Scientific Co-Chair of the Health Research in Humanitarian Crises initiative at the Fogarty International Center of the National Institutes of Health. He co-edited the book, Global Mental Health: Anthropological Perspectives.

Marta Lado
Dr. Marta Lado, Specialist in Internal medicine and Infectious diseases, currently working as the Chief Medical officer for PIH Sierra Leone since 2017. She has been working in Spain with small programs in Sub Saharan Africa about HIV and TB during her spare time, but she decided to move to Sierra Leone in 2014 before the Ebola Outbreak affected the region. She is an experienced clinician specialized in Infectious Diseases and Tropical medicine but also Health Care strengthening and Public Health policies implementation. She manages a skillful and multicultural Clinical team in Sierra Leone and they are planning on improving their program on mental health from the health facility to the community point of view.

Fadi Maalouf
Dr. Fadi Maalouf is the Founding Chief of the Division of Child and Adolescent Psychiatry, Interim Chairperson of the Department of Psychiatry and Associate Professor at the American University of Beirut Medical Center (AUBMC). Dr. Maalouf also holds an adjunct faculty appointment at the University of Pittsburgh, USA. After receiving his MD from AUB, Dr. Maalouf completed a residency in Psychiatry at Harvard Medical School and the Boston VA Healthcare system and a fellowship in Child and Adolescent Psychiatry at Harvard Medical School and the Massachusetts General and McLean Hospitals. Prior to joining AUBMC in September 2009, he was a faculty member at the University of Pittsburgh. Dr. Maalouf’s research interest is in the area of childhood depression and anxiety and he is currently studying school-based interventions that aim at building emotional resilience in Lebanese youth along with Dr. Anne Becker from Harvard Medical School. Dr. Maalouf has received several grants and awards from prestigious organizations such as the American Academy of Child and Adolescent Psychiatry, the American Foundation of Suicide Prevention and the Harvard Medical School Center for Global Health Delivery-Dubai. He is also an elected member of the Alpha Omega Alpha Honor Medical Society and a member of the founding committee of the Arab Board of Child and Adolescent Psychiatry. Dr. Maalouf has published numerous scholarly articles and mentored dozens of students and research fellows.

Haifa Madi
Dr Haifa Madi, MBBS, MPH is currently Advisor to the UAE MOHAP. Before that she was the Regional Director of Health Protection and Promotion Department at the World Health Organization of the Eastern Mediterranean Region Office WHO/EMRO. Prior to that, Dr Madi was the Acting Director of Health, Deputy Director of Health and Chief Health Protection and Promotion Family Health of the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) responsible for the Health programme and services provided to the 6 million Palestinian Refugees in Jordan, Lebanon, Syria, the West Bank and Gaza. Dr Madi received her MBBS in Medicine from the University of Jordan and holds a Master Degree in International Public Health, Harvard School of Public Health. She is also a graduate of the Middle East Educational Fellowship Programme, J.F. Kennedy School of Government, Harvard University. Dr Madi is the author of several published research in The Lancet, the Eastern Mediterranean Health Journal, Plos One Journal, and an author of two chapters in the Book, Neonatal and Perinatal Mortality, Global Challenges, Risk Factors and Interventions, Nova Biomedical.

Jimena Maza
Jimena Maza was born and raised in La Peninsula de Yucatan Mexico, (for her, the Paradise on earth), in a very loving family. She did medical school in La Universidad Autonoma de Yucatan. After she finished medical school, she spent one year working in a rural clinic in a Mayan community
close to Chichen Itza. Since then, she has been working as a clinical supervisor, and most recently as Primary Care Director at Companeros en Salud (CES) in la Sierra Madre de Chiapas, a part of the Partners In Health (PIH) network.

https://healinitiative.org/about/advisors/
http://companerosensalud.mx/

**Marlene Montoya**

My name is Marlene Montoya. I am a Native American woman, from the Navajo Nation, the state of New Mexico. I have an Associates degree in Nursing and plan to continue on for my Bachelor’s degree. I have worked as a Senior Community Health worker for 4 years now. I am fortunate enough to serve my own community of about 800 people, 130 of them being considered elder. As a community Health worker, I do home visits on a daily basis, obtaining vital signs and providing individual health education. During this time, my health educations consist of Hanta Virus, The Plague, and Keeping Hydrated. I also provide education on chronic illnesses. At other times, I am invited to different community events to provide screening and Group Education. I really enjoy what I do as a CHW. Hearing the elders tell their stories of long ago is a joy!

**Hildegarde Mukasakindi**

Hildegarde Mukasakindi bachelor of clinical psychology and a candidate of Master degree of Science in Global Health Delivery at UGH. She has associate director for the Mental Health since September 2017, IMB with main responsibility to work with MoH to develop and integrate high-quality, evidenced-based, culturally sound, patient- and family-centered, community- based mental health systems into the public sector primary care systems in Rwanda. MH Program Manager since January 2014 to October 2017 at IMB / Partners In Health (PIH). From 2010 to 2013 she worked as the Psychosocial Program Coordinator at Drew Cares International (DCI), to ensure integration and implementation of mental health services in HIV and AIDS prevention, care and treatment in Rwanda. Previously, she was also the Rehabilitation Centre Manager for Victim of Violence in Rwanda (FACT-Rwanda) from 2009 to 2010.

www.imb.rw/mental-health

**Laura Murray**

Dr. Laura Murray is an Associate Scientist at Johns Hopkins University, School of Public Health in the Department of Mental Health and International Health; a clinical psychologist by training. She is a co-founder of the Applied Mental Health Research group, which has developed and refined a Design, Implementation, Monitoring and Evaluation (DIME) methodology for use with mental and behavioral health initiatives in low-resource countries. Dr. Murray has extensive expertise in a wide range of evidence-based treatments for mental and behavioral health problems. She has conducted research in a wide range of countries ranging from qualitatively understanding mental health, to full randomized trials of treatments. She has led two randomized controlled trial of Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) with children and adolescents in Zambia examining effectiveness, implementation and HIV-related behaviors. Dr. Murray is co-developer of the CETA approach - a modular, flexible multi-problem transdiagnostic approach built to address implementation barriers. She was a co-Investigator in both of the completed trials with adults in Iraq and Thailand, and the open trial in Ethiopia with refugee children. She is currently leading a trial of CETA in Zambia on the family unit experiencing substance abuse and violence. Dr. Murray is also co-I on a CETA trial in Ukraine with veterans and IDPs. One of Dr. Murray’s primary research areas is implementation science in low-resource countries, examining feasibility, acceptability, fidelity and sustainability, and the effectiveness of implementation strategies for the wider system of care. She has also led the development and validation efforts of Implementation measures for LMIC. Dr. Murray publishes extensively on global mental
health in top journals and regularly speaks at conferences.

**Abhijit Nadkarni**

Abhijit is an addictions psychiatrist and global mental health researcher. He is currently based in Sangath, Goa (India), where he is the Director of the Addictions Research Group. His research interests encompass global mental health, particularly alcohol use disorders in low-resource settings. Currently, he is leading or collaborating on several projects in India funded by grants from MRC-UK, NIHR-UK, and Wellcome-DBT. These include projects as diverse as examining the burden of domestic violence related to alcohol use, and developing and evaluating technology-based interventions for alcohol use disorders and tobacco use. Abhijit is actively involved in the capacity building of mental health researchers and lay health workers. He tutors on the MSc in Global Mental Health, and Leadership in Mental Health courses for the Pacific Islands and Eastern Mediterranean region. He is the also the Course Director on the Leadership in Mental Health, Sangath’s flagship annual international short course in Goa. He continues to train lay health workers in community-based mental health care programmes at several sites in India, and Nepal. He is a member of Government of India’s Ministry of Health and Family Welfare’s task force to develop operational guidelines for the integration of mental healthcare services into a comprehensive primary health care service package.

http://www.sangath.in/addictions-research/

**Sandeep Nanwani**

Sandeep Nanwani MD MMSc is an Indonesian physician who works primarily with homeless populations in Indonesia. He is part of the committee instituted by DKI Jakarta local government to build Jakarta Institute of Mental Health. He works closest with the local department of social affairs to support their efforts in providing care for the homeless with severe mental illness. He sits in the board of several community-based organization and is the medical coordinator of a state supported HIV shelter. He has a Masters in Medical Sciences in Global Health Delivery from Harvard Medical School.

https://www.npr.org/sections/goatsandsoda/2017/11/02/560281649/transgender-women-of-indonesia-have-a-champion-in-a-26-year-old-doctor

**John Naslund**

John Naslund, PhD, is a Research Fellow in Global Health and Social Medicine at Harvard Medical School. Dr. Naslund holds expertise in research methodology, implementation science, social disparities research, and digital mental health. His work seeks to address early mortality that disproportionately impacts individuals living with serious mental illnesses worldwide, and to reduce the global treatment gap for mental disorders using novel digital methods. Dr. Naslund has led numerous projects that leverage mobile technologies, social media networks, and online big data to develop, evaluate, and implement digital interventions aimed at treating and preventing mental disorders. He has over 60 peer-reviewed publications, and has contributed to research projects in the United States, Canada, Haiti, Colombia, and India. Dr. Naslund has a longstanding track record working alongside individuals living with mental illness and community mental health providers, and advocating for the rights, dignity, and quality of healthcare for those facing the challenges of mental illness.

http://www.sangath.in/essence/

**Melino Ndayizigiye**

I am Dr. Melino Ndayizigiye, I am working for Partners In Health in Lesotho as a Clinical Director. I have been working for PIH for the almost 4 years. I am managing three main clinical programs including rural health initiative where PIH supports the Ministry of Health in implementing comprehensive Primary Health Care in rural hard to reach areas of Lesotho, Multi Drug Resistant Tuberculosis (MDR TB) Program where we treat patients with MDR TB from all over the
country and National Health Reform program where we support the ministry of health to improve its health system in four districts. I am also managing innovative projects including integration of Early Childhood Development project that we are piloting in one of our supported rural sites and integration of mental health in the existing health services. Since 2017, we have started capacity building on mental health for PIH and Ministry of Health clinical staff. We have conducted two rounds of training and we have integrated mental health services in our MDR TB services as well as in our rural sites. We have built strong relationship with the ministry of health and have started providing technical support to the ministry of health in the area of capacity building and mentorship on mental health.

Basimene Nhlema

Basimene Nhlema is the Director of Community Health at Partners In Health in Malawi. In this capacity, she leads and manages the Community Health Worker (CHW) program, the Community Programs team, and the Program on Social and Economic Rights (POSER), interdisciplinary teams focusing on community health in a rural and impoverished population. The CHW program manages nearly 1000 CHWs who focus on education and health screening at the household level; the Community Programs team runs an innovative integrated screening program for chronic conditions in remote areas; and the POSER team provides support to patients’ basic social and economic needs. Currently, Basimene is spearheading efforts across PIH departments to modify the CHW services from patient-based to household assignments. The new model will assign CHWs to households with the aim of improving retention in care for clients with chronic, non-communicable diseases, along with increased uptake of women’s health services and treatment for pediatric malnutrition, while sustaining the high retention rates for clients in the HIV program. Previously, she worked as Senior Project Manager for Pakachere Institute for Health and Development Communication (IHDC), contributing to programs that aimed at increasing demand for and utilization of HIV prevention, care and support services among key populations and the youth. Basimene is a graduate of the University of Witwatersrand in Johannesburg, South Africa with a Masters of Arts in Dramatic Arts.

Bethuel Nyachienga

My name is Bethuel, I have been working for the last 27 years in different capacities. I started working as a mental health clinician in 1988 and several various areas including Refugees campus in Kenya, Somalia and Liberia. My trainings include nursing, mental health, HIV AIDS, Clinical trials, community psychiatry counseling, and mental health in complex emergencies. I have rich experience in mental health care, diagnosis, treatment, psychoeducation and follow up of patients that are on care. I do mentorship and supervision to clinicians, trainings to clinicians on mhGAP and emotional support. I do carry out effective awareness strategies, documentation andliaison with gate-keepers. Some of the NGO I have worked with are MSFCH, IOM, GRT, AmeriCares, PIH and Government of Kenya. Projects: I manage a mental health program in one of the counties in South East of Liberia which is one of the hard to reach part of Liberia. In this part of the region Health system was highly affected by the civil war and out break of Ebola, we have many cases of diagnosed or misdiagnosed such as PTSD, Depression, and anxiety. There is high level of stigmatization and discrimination. The program I manage include homeless mental health care, mentorship to clinicians, integration of mental health into the main stream, follow up of patients and training of community health workers.

Dan Palazuelos

Daniel Palazuelos, MD, MPH, is a global health implementer and educator who holds a variety of positions across Harvard, including: Associate Physician in the Department of Medicine, Assistant Director of the Hiatt Global Health Equity Residency in the Division of Global Health Equity, Clinician-Educator
Hospitalist at Brigham and Women’s Hospital, and Cannon Society Global Health Teaching Fellow at Harvard Medical School. Dr. Palazuelos also serves as the Director for Community Health Systems at Partners In Health, and as the Co-founder/Chief Strategist of Compañeros En Salud - México (PIH-Mexico).

**Aneeta Pasha**

Aneeta Pasha is the Director of the Mental Health Program at Interactive Research and Development. She is a Fulbright scholar, with a graduate degree from the Masters of Arts Program in Social Sciences from the University of Chicago, with a concentration in anthropology. She has professional and research experience working in the development sector in Pakistan in the areas of sexual and reproductive health, and mental health. Previously, she worked at the Aga Khan University, School of Nursing and managed the expansion of their academic programs in Afghanistan, Syria and Egypt. She joined Interactive Research and Development in October 2014 and played an administrative/managerial role in various international programs in Uganda, South Africa, and Ethiopia, Malawi, etc. Currently, she is overseeing the expansion of IRD’s mental health program into a large private sector network of primary care clinics in Pakistan, using a community-based model.

**Vikram Patel**

Vikram Patel is The Pershing Square Professor of Global Health and Wellcome Trust Principal Research Fellow at the Harvard Medical School. His work has focused on the burden of mental disorders, their association with social disadvantage, and the use of community resources for their prevention and treatment. He holds Honorary Professorships at the Harvard TH Chan School of Public Health, the Public Health Foundation of India, and the London School of Hygiene & Tropical Medicine (where he co-founded the Centre for Global Mental Health in 2008), and is a co-founder of Sangath, an Indian NGO which won the MacArthur Foundation’s International Prize for Creative and Effective Institutions in 2008 and the WHO Public Health Champion of India award in 2016. He is a co-founder of the Movement for Global Mental Health. He is a Fellow of the UK’s Academy of Medical Sciences and has served on several WHO expert and Government of India committees, including the WHO High Level Independent Commission for Noncommunicable Diseases and Mental Health. He has been awarded the Chalmers Medal (Royal Society of Tropical Medicine and Hygiene, UK), the Sarnat Medal (US National Academy of Medicine), an Honorary Doctorate from Georgetown University, the Pardes Humanitarian Prize (the Brain & Behaviour Research Foundation), an Honorary OBE from the UK Government and the Posey Leadership Award (Austin College). He was listed in TIME Magazine’s 100 most influential persons of the year in 2015.

**Gloria Pedersen**

Gloria Pedersen received her MSc in Global Mental Health in 2017 from King’s College London and the London School of Hygiene and Tropical Medicine, and currently works as a research associate with Dr. Brandon Kohrt at the Global Mental Health Lab, The George Washington University, Washington, D.C. She previously worked in developmental psychobiology at Weill Cornell Medical College, supporting research on healthy adolescent brain development, risk-taking behaviors, and cognitive control with emotional influence in patients with borderline personality disorder and patients with bulimia nervosa. Prior to joining as a research associate at GWU, Gloria worked in London at the Centre for Global Mental Health and with War Child Holland on various research topics including depression and HIV-treatment adherence in Zimbabwean adults, comorbid anxiety and depression in adolescents, and family-based psychosocial interventions for youth outcomes in LMICs. Current projects include: Identifying Depression Early in Adolescence (IDEA): a multi-site study (UK, Brazil, Nigeria, and Nepal) aiming to understand common global risk factors, including psychological, social, biological markers, brain-related
abnormalities, which contribute to the onset of depression in young people (10-24 years old).

https://www.mqmentalhealth.org/research/profiles/identifying-depression-early-in-adolescence

EQUIP - Ensuring Quality Psychological Support, a WHO workforce development package for psychological interventions.

**Inge Petersen**

Inge Petersen, PhD, is Director of the Centre for Rural Health (CRH) in the College of Health Sciences at the University of KwaZulu-Natal, Durban, South Africa and visiting Professor in the Department of Health Service and Population Research, Institute of Psychiatry, Psychology and Neuroscience, Kings College, London. She has published over 100 peer review publications and over 20 book chapters and has extensive experience in integrated mental health care in low- and middle-income countries (LMICs). Currently she is a principal investigator of the COBALT (Comorbid Affective Disorders, AIDS/HIV, and Long Term Health) trial and country principal investigator for the Programme for Improving Mental Health Care in South Africa - a 5 country research consortium. Both studies are concerned with the development and evaluation of integrated mental health care for co-existing mental physical conditions. This body of work is being scaled up in South Africa with the support of funding from the Centers for Disease Control and Prevention (CDC) through the Mental Health Integration (MhINT) project; evaluated through the Southern African Mental Health Integration (S-MhINT) research consortium funded by NIMH, of which she is the overall hub lead.

https://crh.ukzn.ac.za/

**Nishat Rahman**

Nishat Fatima Rahman, Ph.D is the Academic Head of BIED’s MSc. in Early Childhood Development Program and Center for Psychosocial Wellbeing. Since October, 2017 she has been also working as the lead of MHPSS for humanitarian crisis management project at Cox’s Bazar for the Rohingya population. Major areas of interest in research include impact of play in early years, intervention design and its effect on children’s developmental aspects, mental health support for mothers, socio-emotional and developmental outcomes for children and adolescents. Professional expertise also includes academic course designing and curriculum development, trainings and project-designing for early years, adolescents and mothers. Projects: Child protection through playful early stimulation and psychosocial support for displaced Rohingya Children at Cox’s Bazar, Bangladesh

**Giuseppe Raviola**

Giuseppe (Bepi) Raviola is an Assistant Professor of Psychiatry and of Global Health and Social Medicine at Harvard Medical School. He is Director of Mental Health for Partners In Health (PIH), and Director of the Program in Global Mental Health and Social Change at Harvard Medical School. A board-certified adult and child/adolescent psychiatrist, he is an attending physician at Boston Children’s Hospital. In the Department of Global Health and Social Medicine Dr. Raviola works to advance efforts related to training and education, and research, seeking to promote excellence in global mental health care delivery in the countries with which the program partners and at HMS. He is a collaborator in the development of a new cross- Harvard initiative, GlobalMentalHealth@Harvard. In his role with PIH he works to integrate mental health services into the care provided at PIH sites, supporting local team leaders in Haiti, Rwanda, Sierra Leone, Liberia, Malawi, Lesotho, Mexico and Peru on issues related to mental health care delivery and program implementation. Dr. Raviola’s scholarly contributions center on the integration and application of quality improvement and public health approaches in innovating clinical practice, teaching and research in the domains of psychiatry and global mental health. This work meets a critical local and global need for innovative
mental health delivery solutions, given the significant global burden of mental disorders, and the universal shortage of specialists to address this burden.

**Alex Riley**

I’m a science writer currently working on a book into the treatment of depression around the world. It was bought by Scribner (Simon and Shuster) in the US and Ebury (Penguin Random House) in the UK in 2017 and is set to be published in spring 2020. I am also working on a feature for the Wellcome Trust’s magazine, Mosaic Science, into the treatment of depression in low-income countries with lay-health workers.

**Christian Rusangwa**

Christian Rusangwa, MD is a trained physician with passion for global health working for Partners In Health as a Deputy Chief Medical Officer in charge of Chronic Care, and finishing a Master’s of Science in Clinical Research at the University of Liverpool. In his current role he is also a member of the senior leadership team at Partners In Health/Inshuti Mu Buzima; where he is responsible for providing support and guidance in the area of district health system strengthening building in relation to the decentralization of NCDs care based on the Rwandan Ministry of Health Sector Strategic Plan III and PIH strategic plan. His role includes supporting the provision of NCDs care at the district hospitals and health centers in Rwinkwavu, Kirehe and Burera. In his capacity as the Deputy CMO Christian also works with the Rwanda Biomedical Center NCDs and Mental health divisions to devise strategies to expand specialty care in primary healthcare system. He has been co-leading an innovation project on the integration of mental health in primary care service funded by the Grand Challenge Canada. He is involved in several implementation research activities as Principal investigator and co-investigator and won an emerging young talent in research award in 2015 and received an exemplary leader award at Partners In Health in 2014. For the past 10 years he has been involved in several public health endeavors from the community level as a grassroots activist volunteering for Rwanda Village Concept Project in 2005, then worked as an intern and later on as attending physician at Kirehe and Butaro hospital between 2010 and 2012 respectively. In 2011 He got involved with the Clinton Health Access Initiative on study looking at the unit cost of providing ARVs in Rwanda. In Mid to late 2012, He served as a camp physician in a Congolese refugee camp hosting about 14,000 refugees. Where He had the task of leading the provision of care for refugees and ensure adequate referrals are in place. He is interested in implementation science and get involved in community service as a volunteer in his spare time. Christian has interest in design and implementation of service delivery platform as well as economic evaluation. Below are some published work in which he has been involved and his other work.

http://ascopubs.org/doi/full/10.1200/JGO.17.00003
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5579417/
http://www.grandchallenges.ca/grantee-stars/0594-04/#description
ughe.org/
medical-education-global-health-equity/
http://www.newtimes.co.rw/section/article/2008-06-07/87845/
http://www.healthynewbornnetwork.org/blog/all-babies-count-caring-for-newborns-in-rwanda/

**Alison Schafer**

Currently working as a technical specialist in the dept of mental health and substance abuse at WHO. Prior experience includes 8 years a global MHPSS technical advisor with World Vision International’s Humanitarian and Emergency Affairs team; with engagement in multiple global mental health initiatives (e.g., PM+, IASC MHPSS Reference Group, M&E, PFA). A further 9 years of experience in the global humanitarian context as a programmer and communications manager. Projects:

Currently working on a project for WHO, called
EQUIP: Ensuring Quality in Psychological Support. The project is establishing a framework for the competency of helpers, trainers and supervisions with a particular focus on potentially scalable psychological interventions.

**Rahul Shidhaye**

Dr. Rahul Shidhaye is a Public Health Psychiatrist. His research work is mainly in the areas of integration of mental health in primary care, mental health systems strengthening and implementation science. He is Principal Investigator for NIMH funded ESSENCE (Enabling translation of Science to Service to Enhance Depression Care) project and country Principal Investigator for various Research Program Consortiums such as PRIME (Program for Improving Mental Health Care), EMERALD (Emerging Mental Health Systems in Low and Middle Income Countries) and SHARE (South Asian Hub for Advocacy, Research and Education on Mental Health) and VISHRAM (Vidarba Stress and Health ProgRAM).

**Siham Sikander**

Since the last 13 years, I have been working on maternal psychosocial well-being and child development in Pakistan. My focus has been on task-shifting interventions through community health workers. Using implementation and cluster randomized trial designs, I have been developing and testing interventions for mothers and children. I have worked closely with the health systems of Pakistan and have developed close linkages with the Ministry of National Health Services, NGOs, and a number of academic institutions that work to address public health issues of Pakistan.

**Daisy Singla**

Daisy R. Singla is a clinical psychologist, clinician scientist, Assistant Professor and Distinguished Fellowship in the Medical Psychiatry Alliance in the Department of Psychiatry at the University of Toronto. Her main areas of interest involve the development and evaluation of complex, integrated psychological treatments, including the systematic evaluation of therapy quality, in low-resource settings. To date, Dr. Singla has led or contributed to complex trials focusing on child growth, health and development, as well as maternal mental health in rural Uganda, Ethiopia, Bangladesh, India and Pakistan. She has served as an advisor to the WHO for several years in areas of evaluating maternal and child health programs as well as competency of non-specialist providers delivering psychological treatments. Dr. Singla aspires to address bottlenecks to ultimately improve access to evidence-based psychological treatments to enrich the lives of women and their families worldwide.

**Stephanie Smith**

Stephanie L. Smith, M.D., is the Deputy Director of Mental Health at Partners In Health (PIH), an Associate Psychiatrist at Brigham and Women’s Hospital (BWH) in Boston, MA, and an Instructor in Psychiatry at Harvard Medical School (HMS). She also holds appointments in the Division of Global Health Equity at BWH, and the Program in Global Mental Health and Social Change at HMS. In her role at Partners In Health, Dr. Smith provides clinical and programmatic support for mental health integration across all the PIH sites, including Rwanda, Haiti, Mexico, Malawi, Lesotho, Sierra Leone, Liberia, and Peru. Dr. Smith’s current research interests focus on global mental health implementation science, particularly in evaluating outcomes and impact of task-sharing endeavors for mental health care across the Partners In Health sites. Dr. Smith continues to provide clinical care as a consultation-liaison psychiatrist at the Brigham and Women’s Hospital, and actively teaches and mentors students and trainees at all levels, including medical and professional students, psychiatric residents and fellows, and other allied health professionals. 

https://www.pih.org/programs/mental-health
Archana Sudhakaran

I am a clinical social worker from India. I have mostly worked in tertiary care clinical settings. During the initial few years of my career, I worked in a child guidance clinic with a multi-disciplinary team that catered to children with developmental disorders. Later I got the opportunity to work in a program for homeless women with severe mental disorders. For the last few years I have been part of an Indian philanthropy that has played a pivotal leadership role in the mental health sector. Its involvement extends beyond providing financial help to initiating and supporting innovative programmes across the country. Currently I am working on a project by name Udaan (meaning “flight”). This is a unique initiative to reform and transform institutions providing mental health care in India. Udaan envisages a reform process that enhances the quality of care received by the service users; that safeguards their dignity, promotes their rights, works toward their autonomy and their empowerment, all this leading to their return to and participation in civil society. We have initiated this program in one of the oldest psychiatric institutions (more than a century old) in Central India. The program is participatory in nature and is in collaboration with the State Government. Another major project that we are planning to implement soon is a community mental health Program in one of the districts in Central India with a total population of 46 lakhs. This is also a collaborative program with the State Government. The program is being designed with a view to providing services at the primary care level using a non-specialist work force based on the principals of task shifting and task sharing. We are currently in the preparatory phase of this project.

Cidna Valentin

Dr. Cidna Valentin joined Partners In Health | Zanmi Lasante (PIH | ZL) in May 2015 as the Training and Quality Improvement Psychologist. Cidna provides clinical support to the staff of psychologists across 12 ZL sites and programmatic support to the ZL Mental Health leadership team based in Mirebalais, Haiti. She holds a PhD in Clinical Psychology and prior to working for PIH | ZL, Cidna was involved in Haiti’s educational sector through the City University of New York’s (CUNY) Haiti Initiative, a partnership with four Regional Public Universities (UPRs) around Haiti.

Lena Verdeli

Lena Verdeli, Ph.D, MSc, is an Associate Professor of Clinical Psychology; Director of Clinical Training at Teachers College, Columbia University; and the Founder and Director of the Teachers College Global Mental Health lab. Over the years Dr. Verdeli has been receiving funding from federal (NIMH) sources, international agencies (WHO, UNHCR), and foundations to study psychotherapy for prevention and treatment of mood disorders. In the past fifteen years Lena Verdeli has played a key role in landmark studies involving adaptation, training, and testing of psychotherapy packages used by both specialists and non-specialists around the globe (psychologists, psychiatrists, primary care staff, community health workers, etc). She collaborated internationally with academic groups, ministries of health, local NGOs and international agencies to alleviate the suffering of adults locally defined as depressed in southern Uganda; war-affected adolescents in IDP camps in northern Uganda; traumatized IDP women in Colombia; distressed patients in primary care in Goa, India; depressed community members in Haiti; and war-affected Syrian refugees in Lebanon, among others. Dr. Verdeli is a Scientific Advisory Council member of the American Foundation for Suicide Prevention, and the Scientific Advisory Board of Depression and Bipolar Support Alliance. She received the Klerman Young Scientist award; the APA Division 52 Mentoring Award; and chaired the research workgroup of the Family NGO at the UN. She is the first author of the manual on Group Interpersonal Psychotherapy which has been disseminated globally online by WHO (http://www.who.int/mental_health/mhgap/interpersonal_therapy/en/).
Inka Weissbecker
Dr. Inka Weissbecker, Ph.D., MPH is the Senior Global Mental Health and Psychosocial Support (MHPSS) Advisor for International Medical Corps. In this role, she provides remote and on-site technical oversight and support to project countries in the areas of assessment, program design, project implementation, and evaluation of MHPSS programs in over 20 countries. Over the past eight and a half years with International Medical Corps she has completed field assignments in South Sudan, Ethiopia, Sierra Leone, Liberia, Malawi, Libya, Jordan, Lebanon, Gaza, Turkey, Syria, Greece, Afghanistan, Pakistan, Ukraine and Japan. At the global level Dr. Weissbecker has led several projects to develop mental health guidelines and materials in collaboration with key organizations such as WHO and UNHCR. She has also been a contributor to several global IASC and WHO guidelines and working groups and has published many reports, peer reviewed publications and book chapters about improving mental health in conflict and crisis affected countries. Her academic credentials include a PhD in Clinical Psychology specializing in health and public sector psychology from the University of Louisville and University of South Florida as well as an MPH in Global Health and Population Studies from the Harvard School of Public Health.

https://internationalmedicalcorps.org/program/mental-health-psychosocial-support/

Sandra Willis
Dr. Willis is a psychologist by profession with 20 years of experience in academic, government and non-government organizations engaging in teaching, mentoring, research, social policy and social development activities leading to leadership roles that emphasize turnaround strategies. A versatile professional consistently achieving goals and moving from vision, research, policy and strategy to implementation, she is adept at designing academic, social development and capacity building plans. Dr. Willis received her doctorate in Psychology with a specialization in intellectual & developmental disabilities and has worked in academia as an Assistant Professor of Psychology at Zayed University and California State University Fullerton. In the private sector, she worked as a consultant in developing social services (early childhood development and early intervention centers and social enterprise development) and co-founded an inclusive early learning. For the past 12 years Dr Willis was responsible for providing strategic advice on integrated social, health, and economic prosperity in Dubai via policy, legislative and programmatic recommendations based on the Dubai Strategic Plans including a Dubai-wide master plan for service delivery, human resources, partnership development and capital investment. The approach included applied research tools, rigorous analysis, monitoring and evaluation, to ensure that all strategies and policies are contextually appropriate, fiscally responsible, are evidence-based thereby meeting international standards. Specifically, she worked developing macro-level social development objectives by conducting comprehensive needs assessments measuring the current health and social status and needs of the population to inform policy development, including assessment of policy impact and cost effectiveness. Some initiatives include the Dubai Disability, Mental Health, Early Childhood Development, Parenting and Vocational Education Strategies.

Projects: My academic research, community outreach, and consultancy activities include the areas of social policy in inclusive development and disability rights, mental health, parenting, and early childhood development and education. In the private sector, I worked as a consultant in developing social services (early childhood development centers, early intervention center, and social enterprise development) and co-founded an inclusive early learning. I continuously
aspire to be a versatile professional striving to achieve goals that move from vision and strategy to collaborative implementation that build social capital. Throughout my career I have always sought opportunities to contribute toward varied humanitarian development activities with International Agencies on a broader scale, in an attempt to have greater impact. Currently, I am an advisor on various social development strategies.

**Jesse Wilson**

Jesse Wilson is currently at Partners In Health as a Mental Health Evaluation, Quality and Technology Manager. Previously, Jesse worked for the U.S. Agency for International Development in the Global Health Security and Development Division, where she worked on development programming aimed at mitigating the second order health impacts of Ebola in West Africa. She has also worked on evaluating the impact of refugee mental health programs with Save the Children, Catholic Charities and the US Committee for Refugees and Immigrants (USCRI). She has experience in survey development, data visualizations and quality improvement. Jesse holds a Bachelors degree in International Affairs from George Washington University and a Masters of Science in Global Health and Population from Harvard T. H. Chan School of Public Health.

**Sheena Wood**

Sheena Wood is a Research Assistant in the Department of Global Health and Social Medicine at Harvard Medical School. In this role, she has supported the launch of a new GlobalMentalHealth@Harvard initiative, helped develop two new courses to be taught at Harvard Medical School and the Harvard School of Public Health, and assisted with various research projects aimed at reducing the treatment gap for mental illness. Prior to working at Harvard Medical School, Sheena was a Fulbright scholar at Sangath in Goa, India, where she conducted a research project exploring the experiences and challenges of lay mental health workers across India. She also worked for three years at Partners In Health, growing a program focused on building the movement for the right to health through community organizing and grassroots advocacy. Sheena graduated from Brown University with a degree in Public Health and will begin a psychiatric mental health nurse practitioner program at the Massachusetts General Hospital Institute of Health Professions next fall.

**Sakila Yesmin**

Sakila Yasmin has been working as a Senior Lecturer and Researcher at BIED since January 2009. She holds M.Phil and Masters in Psychology from the University of Dhaka and second masters in International Health from Humboldt University, Germany and Post Graduate Diploma in Health Economics and Public Health. Currently she is pursuing her PhD on adolescent mental health. She is trained in different Psychotherapies and Psychological Assessment. From 2013 to 2014 she was the coordinator of the psychosocial counseling team. Sakila works on and supervises in designing masters course in ECD and Mental Health, front-line counseling course, psychosocial model for teachers, health workers and training and implementing the model. Over the few years, she has provided assistance and support to child development programs and research in Uganda and Tanzania. She works as principal investigators of several researches to develop low cost intervention for wellbeing of underprivileged children and their mothers. She works in a multitude of projects including Play based model, Parenting, SSCOPE, counseling support for Rana Plaza victim, Nobodara School, emergency response for Rohingya refugees in Bangladesh - efficient time management and helpful colleagues are her saviors. She is also overseeing the M&E team. Projects: We have conducted three studies on maternal and school mental health and some are published. Now we are going to conduct several studies on mental health in emergency crisis of Rohingya refugees.