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Importance of interactive small group discussions to educate community health workers

Laurel Paul[a], Grace Warkulwiz[a], Abdalla Nassar[a], Khanjan Mehta[a]*

[a]*Humanitarian Engineering and Social Entrepreneurship (HESE) Program, The Pennsylvania State University, 213U Hammond Building, University Park, Pa 16802 USA*

Abstract

Community health workers (CHWs) are an effective solution to address the double burden of chronic and infectious diseases in developing countries. Due to limited resources, CHWs seldom receive adequate training. A standardized training regimen with three educational methods was tested with CHWs in Kenya to identify the optimal method. CHWs were divided into three breakout groups each testing a different pedagogy. It was concluded that each method was equally effective. Interactive small group learning methods do not require additional resources and can be easily integrated into CHW training regimens to produce better-prepared health workers.

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Keywords: CHW; training; interactive education; healthcare; small group discussion

1. Background

Hardships faced by health care systems in developing countries, particularly in Africa, include high child mortality rates and a double disease burden [1,2]. The focus of many health systems is on acute illnesses even though there has been a shift toward chronic and non-communicable diseases worldwide [3]. In 2010, non-communicable diseases were responsible for two of every three deaths globally [4]. For these diseases, early identification of risk factors and improved lifestyle choices can prevent worsening of the illnesses [5].

There is ample evidence that the double disease burden in developing countries can be mitigated with help from Community Health Workers (CHWs) [6]. CHWs are volunteers who close the gap between communities and health facilities that are often inaccessible to the general public [3]. The International Labour Organization defines CHWs

* Khanjan Mehta. Tel.: 814-863-4426.
E-mail address: khanjan@engr.psu.edu

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as community members selected by their communities to provide basic primary care [7]. The tasks normally performed by doctors can be shifted to local CHWs, who are able to make frequent home visits to aid people with health concerns. They provide their communities with education on basic public and environmental health and first aid treatment [6]. Since CHWs are part of the communities they serve, they share many characteristics with those they are helping, including language, socioeconomic status and ethnicity [8]. This enables CHWs to convey health information using the local language and value systems, putting it into the context of the community [6]. CHWs can be effectively employed to aid persons with chronic and non-communicable diseases [5]. Past CHW interventions among diabetes patients have demonstrated improvement in patient knowledge, self-care and positive behaviour [5]. CHWs can provide essential social support and be a key resource for people with chronic diseases [9]. However, to conduct all of these tasks successfully, CHWs must be properly trained [6].

1.1. Current CHW training

There are vast variations in the organization, length, complexity and approaches to CHW training, resulting in programs operating with varying degrees of success [6]. While conducting their duties CHWs face issues such as lack of resources and funding that affect their ability to conduct their duties. However, ineffectiveness of CHW programs is often rooted in inadequate training regimens [10]. CHWs are typically volunteers offering their services in their limited free time. Another issue is the relaxation of standards during training in rural areas where many CHWs may not meet education prerequisites [11].

The World Health Organization (WHO) suggests six months of initial training followed by six months of on-the-job training [12]. Curriculum can focus on topics like personal hygiene, nutrition and breast-feeding, and more complex issues such as diabetes and hypertension [13]. However, due to a lack of funds, resources and government support, it is often not possible for programs to carry out the suggested training sessions, leading to less-structured, informal training [14]. For example, in Kenya, the Ministry of Health requires CHWs to undergo two weeks of training, followed by regular refresher courses. Unfortunately, many CHWs have not received either of these and must rely only on informal training [14]. There is a distinct gap between what the government intends training to be, and the actual operation of these programs [6].

1.2. Ideal training

There is a need for simple and effective CHW training programs that can be customized and conducted wherever and whenever needed. Past programs have used approaches that were too theoretical for the education level of CHWs, while current ones use more competence-based approaches that are difficult to sustain with available resources [12]. An ideal program would be simple and use methods that require few resources and short implementation times. The WHO suggests that interactive sessions, such as group discussions, should be incorporated to effectively reach less-educated or illiterate CHWs [12]. Small group trainings utilizing multiple learning methods have also had better results [15]. The differing resources and roles at each CHW program location mean any program must be customizable enough to be applicable in different communities. Based on our survey of the literature, a program incorporating interactive education, simplicity and resource conservation has yet to be implemented.

There have been few documented attempts to restructure the way CHWs are trained by addressing current shortcomings. This article presents and analyses the results of a training regimen field-tested with CHWs in Nyeri, Kenya. Its structure was based on addressing the time and funding restrictions of current programs. The regimen tested three educational methods to determine the most successful one, with the goal of ascertaining whether a regimen meeting current program needs could feasibly teach CHWs the information they are required to know. This study was specifically conducted to identify opportunities for integrating cell phones or tablets into the educational regimen. Behavioural cognitive theory was the rationale behind the methods, with the reasoning that inadequate health worker performance comes from a lack of knowledge that can be corrected through teaching [10]. Section 2 of this article outlines the regimen used to conduct the training seminar at each location. Section 3 presents the data and Section 4 discusses the outcomes of the teaching regimen and practical recommendations.