Peoples Webinar: Addressing COVID-19 in LMIC by Building Community Systems

April 15, 2020

THE PREMISE FOR THE WEBINAR

This webinar topic is envisioned from the fact that those who understand building community health systems at community, local, national, regional, and international level need to be at the table to fight the effects COVID-19. There is so much that has been learned by these experts from HIV/AIDS, SARS, MERS, H1N1, and that collective voice is necessary not when the COVID-19 fire has burnt down everything, but rather to mitigate the propagation of its effects.

VERBATIM TRANSCRIPTION

Conducted in partnership with

IT *for* Health and Education System Equity (IT*f*HESE)
And
The African Center for Global Health and Social Transformation (ACHEST)

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PRESENTERS

Dr. (Prof.) Miriam Were: Dr. Miriam Khamadi Were qualified as a Medical doctor from Kenya's University of Nairobi. Then she received both the Masters and Doctor of Public Health degrees from the Johns Hopkins University in USA.Nationally, Prof Were was a Medical Officer in Kenya's Ministry of Health and taught Community Health of the Faculty of Medicine, University of Nairobi. Internationally she has been Chief of Health and Nutrition, Representative of the World Health Organization and Director of the UNFPA Technical Support Team for East, Central and Anglophone West Africa from which she retired in 2000. Post-retirement, she has been Chair of Kenya's National AIDS Control Council, Chair of the African Medical and Research Foundation Board, Member of the Board of the Health Workforce Alliance, Member of the UN Secretary General's independent Expert Review Group (iERG) for Women's and Children's Health, Champions of AIDS-Free Generation mostly made up of Former African Heads of State. She is the co-Founder of UZIMA Foundation-Africa and was Chancellor of Moi University in Kenya. Among outstanding international honours to Prof Were are HIDEYO NOGUCHI AFRICA PRIZE by Japan and The Queen Elizabeth II Gold Medal for Public Health in the Commonwealth. She has Honorary Degrees from Moi University, Honorary Doctorate from Japan's Ochanomizu University and Doctor of Humane Letters from DePaul University, USA. She also has Kenya National Honour of Elder of the Burning Spear for outstanding contribution to the nation and is Kenya's Community Health Strategy Goodwill Ambassador.

Dr. (Prof) Frances Omaswa: Dr. Francis Omaswa is the Executive of the African Centre for Global Health and Social Transformation (CHEST), and chair of the African Health systems Governance Network (Ashgovnet). He co-chairs the Independent Advisory Group to the WHO Director for the African Region. He was Director General of Health Services in the Ministry of Health in Uganda and coordinated major reforms in the health sector. He has a keen interest access to quality health services by rural populations and spent five years testing various approaches for this at the Ngora Mission hospital in Uganda.He has been President, African Platform on Human Resources for Health (APHRH), Special Adviser to the World Health Organization (WHO) Director General and founding Executive Director of the Global Health Workforce Alliance (GHWA). He is founding Director of the Uganda Heart Institute at Makerere University, Uganda; founding President of the College of Surgeons of East, Central and Southern Africa, chair of the GAVI Independent Review Committee, founding Chair of the Global Stop TB Partnership, Chair of the Portfolio and Procurement Committee of the Global Fund Board. He was a member of the steering committee of the High Level Forum on health-related MDGs. He serves on committees and expert panels. Francis Omaswa is a graduate of Makerere Medical School, Uganda and has qualifications in surgery, health services management and medical education.

Dr. (Prof) Suwit Wibulpolprasert: Dr. Suwit Wibulpolprasert is a general practitioner, a public health specialist, an administrator and a policy advocator. He began his career as a director and a practitioner in four rural district hospitals in Thailand from 1977 to 1985. Later he was the Director of the Northeastern Public Health College, Director of Technical Division of the FDA, Director of Bureau of Health Policy and Plan, Assistant Permanent Secretary, Deputy Permanent

Secretary, and Senior Advisor at the Thai Ministry of Public Health. His main interests are in health policy and planning, and international health. He has been extensively involving in research and development in the areas of human resources for health; health economics and health care financing; international trade and health; health promotion; health information; and pharmaceuticals. He has published more than 100 papers, reports and books locally and internationally. In Thailand, Dr. Suwit is the editor of a local journal for para-medical personnel and had produced radio and television programs on health and social issues for more than 15 years. He is currently the President of the Folk Doctor Foundation; Evaluation Board member of the Thailand Research Fund; and Board member of the Health Systems Research Institute, the Thai Health Promotion Foundation, the National Health Security Board, the Thai Medical Research Council, the National Nanotechnology Centre, the Mahidol University Council, and the National Science and Technology Board. Besides all these works, he has run 8 marathons. For international involvements, he represents Thailand in many international health forums and the World Health Assembly. He also represented Thailand and the South- east Asia Region as a member and Vice Chair of the Governing Board of the Global Fund to Fight AIDS, TB, and Malaria in 2001-2004. He was the President of the Intergovernmental Forum on Chemical Safety in 2003-2006 and a member and Vice Chair of the WHO Executive Board during 2004-2007. He also chaired the Board of the Health Metrics Network in 2006-2007. At present, Dr. Suwit chairs the Steering Committee of Asia Partnership on Avian Influenza Research and the Steering Committee of Asia-Pacific Action Alliance on HRH. He is also a member and Chair of the Program Coordinating Board of the UNAIDS, and member and Chair of the Program and Policy Committee of the interim Board of the Global Health Workforce Alliance. Dr. Suwit served as a Deputy Permanent Secretary of the Thai Ministry of Public Health, in 2000-2003. Currently, he serves at the highest rank of government official (PC11) as a Senior Advisor in Disease Control, after serving as a Senior Advisor in Health Economics during 2003-2006. He is also responsible for health policy and international health works of the ministry.

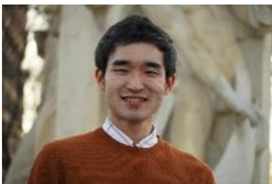
MODERATORS

Dr. (Prof) Seble Frehywot: Dr. Seble Frehywot is an Associate Professor in the Department of Global Health and the Department of Health Policy& Management at The George Washington University (GWU). Currently, she is also the Director of Health Equity On-Line Learning for the Atlantic Philanthropy Atlantic Fellows for Health Equity program. She has twenty-four years of experience in international settings spanning Asia, Africa, and the United States, and brings an in-depth knowledge of comparative health systems, communities of practice (CoP), medicine, health policy and e-learning to the challenges of building the components of a health system. Her main work focus is in lower and middle-income countries. She has comprehensive knowledge of digital health technologies acquired and honed from over nine years of background in digital health education and technologies in low- and middle-income countries (LMIC). She also has hands-on background in strategically coordinating with the public, other sectors, and health systems stakeholders (government ministries, academia, non-governmental organizations, regulating bodies, and the private sector) with regard to health equity issues surrounding health workforce training, quality and safety regulatory frameworks, pedagogy, e-pedagogy, and e-andragogy. Dr. Frehywot has worked as a Technical Core Group member for the World Health Organization for the development of a number of WHO global guidelines and recommendations related to health systems. She has provided senior-level influence as a principal

investigator and director for numerous multimillion-dollar international projects and has published a number of papers related to health workforce and health systems as well as to the linkages with ICT. She teaches at The George Washington University both in an online and residential format the Global Comparative Health Systems, Global Health and Development and Global Public Health Culminated Experience courses.

Dr. (Prof.) Yianna Vovides: Dr. Yianna Vovides' work intersects three areas – education, technology, and development. Over the last two decades, she has focused her practice and academic efforts in addressing how people learn within networked learning environments. She has worked on projects that emphasize individual and group learning, institutional programs that enable systemic changes, and research that examines how new technologies support teaching and learning. Professor Vovides currently serves as Director of Learning Design and Research at the Center for New Designs in Learning and Scholarship (CNDLS), Professor for the Master of Arts in Learning, Design, and Technology (LDT) program at Georgetown University, and Curriculum Director for LDT, Georgetown University. In her role at CNDLS, she oversees the online learning, technology-enhanced, and development efforts. She has over 15 years of experience in higher education and has been instrumental in establishing programmatic efforts for university-wide services in online learning. Professor Vovides also serves as Curriculum Director for LDT. In this role, she convenes and seeks out input from both faculty and students on how to implement, adjust, and improve the curricular connections among courses across the program's core courses and all tracks.

TRANSCRIBER



Mr. Charles Park: Chulwoo "Charles" Park, MSPH, is a DrPH candidate studying global health, specializing in epidemiology and biostatistics for underserved populations, and graduate teaching/research assistant at The George Washington University Milken Institute School of Public Health. He holds two Bachelor of Science degrees in Biology and International Studies from The University of Utah and a MSPH degree in International Health from Johns Hopkins Bloomberg School of Public Health. He is a motivated global health researcher and professional with several years of domestic and international fieldwork research experience focused on community health, refugee and immigrant health, control of infectious disease, and healthcare management in the United States, sub-Saharan Africa, and Southeast Asia. He worked as a global health fellow, family mentor, community health educator, and peer advisor at World Vision International, International Rescue Committee, and various educational institutions. Through a strong background of both quantitative and qualitative method skills, he has published many peer-reviewed research papers about medical diaspora, water, sanitation, and hygiene (WASH), ethnomedicine, and gender minority issue in low- and middle-income countries. In addition, he has worked as a graduate teaching assistant for four years for fourteen different global health graduate-level courses. For his doctoral dissertation, he is focusing on the analysis of DrPH education in the United States to measure its impact and suggest the future directions. He was an exemplary airman and served on the reserve force of Republic of Korea Air Force.

VEBATIM TRANSCRIPTION

0:00:02
Seble Frehywot: ... COVID-19 through building community health systems. This webinar was prepared with partnership of ACHEST Uganda, which is the African Centre for Global Health & Social Transformation led by Professor Dr. Francis Omaswa and the IT for Health Education and System Equity (IT fHESE), which is led by myself as well as Dr. Yianna Vovides at the George Washington University as well as at the Georgetown University. Before we start, there are a number of people that have registered for this webinar. And as I speak they are joining us. We ask that you keep your audio on mute. We will be recording this webinar and we will be posting a link for this webinar on our site. This webinar topic is envisioned from the fact that those who understand with first-hand experience of building Community Health Systems at household, local, national, regional, and international level need to be at the table to fight the effects of COVID-19 in low- and middle-income countries.

0:01:38
Seble Frehywot: Besides the people that are introduced shortly that would be the speakers. There are a number of you that have joined that have worked at this level in many low= and middle-income countries through many pandemics. Your collective wisdom is very much needed. There's so much that we have learned by this expert, through experts, and to the attendees from HIV/AIDS, SARS, MERS, H1N1, and Ebola and that collective voice is necessary not when COVID-19 fire has burned down everything but rather to mitigate the propagation of its effects and build for the future. I'll now give time to Professor Francis Omaswa to do an introduction and then I will introduce the speakers. Dr. Omaswa?

0:02:42
Francis Omaswa: Hello, Seble and friends. Good morning. Good afternoon. Good day, whatever ... wherever you are around the world. I want to join Seble in welcoming us to this very important discussion on a topic that is extremely relevant to not just the struggle with COVID right now but also to the future health systems after COVID. So I don't really have much to say now unless Seble, you want me to start to make my very short statement on the topic.

0:03:33
Seble Frehywot: Thank you so much Dr. Omaswa. Let me introduce who are our speakers and then I'll give you the mic to start of this webinar to Dr. Omaswa. So I'm deeply honored both us and access were deeply honored to have with us. Dr. Professor Miriam Were from Kenya as well as Professor, Dr. Suwit from Thailand. The bios of these people are on the webinar site, but as you can see from their bios, and I'm sure as most of you know them from other interactions. These three people have built community level system. That's so much needed in during pandemic times during the past few pandemics. So right now I'll be giving them mic to Professor Omaswa so that Professor Omaswa can lead us into this discussion.

0:04:39
Francis Omaswa: Again, good good. Good morning afternoon, evening, all of you. So we are living at a very strange time in human history. We are all now locked up in our homes. Offices are closed. Places of worship are closed. And how did we come here? And how do we get out of here? And that I believe is what we want to achieve the answers to those questions are what we want to achieve through this

discussion. So community health systems is about the health of people. Health is inborn. The majority of us except for those unfortunate to be born with congenital malformations and illnesses. Most of us born healthy. We grow up healthy, we aged healthy, and our bodies have got inbuilt mechanisms to ensure that we remain healthy the in mediaintria (?), which we learnt from our physiology days as young people. So the responsibility to maintain this inborn health is essential with us. Individuals obeying our bodies it is essentially with us as families and households supporting each other to keep the healthy people healthy and it is then with households and the communities in which those households lived that is where the responsibility lies. Yes. We need government. We need government to come in to support us with those services that we cannot provide ourselves as the individuals, households, and members of communities, But first and foremost, we should be the ones who are aware that the inborn health that we have should not be taken for granted. And that health is made in our homes. The health facilities only come to maintain it and maybe to make repairs when it has been damaged. And so that message needs to get to all people, all people need to get that message because in many situations is taken for granted. It is assumed that they are people who look after our health outside there in the clinics and in the hospitals and so on so. We don't recognize that those places are there as a second step. That the first stop is we the owners of the bodies and those families who are responsible maybe for children and for other members of their families and communities.

0:08:01
Francis Omaswa: To me, I feel that if we are able to get that message, round to all people that is when we will be making real start. To answering the questions about how did we come to remain in our homes to stop going to our offices to work? So the most places particularly in rural Africa, communities been well integrated. They are suffering now from pressures of new lifestyles and so on, but they are still there. And I worry that if this COVID, COVID-19 starts to spread inside the African communities. The only way to stop is through using the communities themselves. The only way will be to win the trust of the people and to get them to be the ones who are responsible for identifying those who are not well, referring them for support. Where are we now? We expect the government to come in tracing contact contacts and so on not hiding the seek in knowing about the dangers of those who died and once the people trust us, or trust the health system, then we are there. And they are administrative leaders in all these rural communities. Some of them are called Chiefs (?) and as provided by different names and this should be their job, but very often this is not their job. They are political systems in the communities, but very often many of them are there to monitor politics who is trying to destabilize the government to oppose the government but not to ask the question, how is the health of the people? What are the health threats o the people? So we need to be moving in that direction using COVID as the trigger because it seems to me that everyone around the world, particularly our political leaders have been touched by this pandemic and probably will be willing to listen this time in spite of the fact that we've had experienced this before and they forget. This one has been the biggest that has it the world may be as long as our history.

0:10:51
Francis Omaswa: Our recorded history is concerned causing such a global closed down. There have been other big ones that this I believe is the biggest. So let's learn from this, let the world be different from this in the future and let's build health system which are focus on keeping healthy people healthy through the participation of everyone as a duty and the right having recognized that the responsibility for their health. First and foremost is their own and not that of the government or other people. So let me start stop there for now and be quite happy to come back again. Thank my colleagues.

0:11:56
Seble Frehywot: Be ourselves our owners of our body and we need to empower each and every community member on the ground. In the country I was born I was born in Ethiopia. There is a saying that says 50 lemons are too much to carry for one human being but they are not too much to carry for 50 people. So getting the collective voice of everyone that is doing this webinar and those that have joined that know how to build systems is imperative in really addressing this vicious virus at the ground level. Next, I'll give the mic to Professor Miriam Were. Welcome Professor Were and if you can give us your introductory remarks. It's yours.

0:12:42
Miriam Were: Thank you very much, Professor Seble. It is my great joy and pleasure to be part of this panel. Professor Omaswa has given us...

0:12:59
Seble Frehywot: We lost your voice, Professor Were. Are you able to hear me Professor Were?

0:13:15
Miriam Were: ... of the...

0:13:18
Seble Frehywot: We lost your voice. Can you start all over again, please?

0:13:25
Miriam Were: With something ... audio system. I said, I'm very happy to be here on this panel and if you have had Professor Francis Omaswa give us the opening remarks. Pointing out the importance of the individual and the family in our health, I would like to mention... can you hear me now?

0:13:54
Seble Frehywot: Yes, we can hear you very well.

0:13:56
Miriam Were: Okay, I would like to state that in addition to the individual and the family, the health sector is very important in helping to organize community health systems. The family may be organized. The family is responsible the health, but the reality that I have faced in my years of work in communities is that there isn't only as information in the community about helathy people. The cost is especially the causes of un..(?) health. For instance, I have found ... that ...(?) is caused by the heat of the pregnant woman. So they don't see any anything they can do about it because the woman is expecting a baby. So then that the baby before that must be must have ...(?) But we know that that is not the case. So there is in there is lack of information. And this is where the Ministry of Health of every country should ensure that because the individual and the community are so important. They are properly informed. And in this COVID-19 pandemic, I did that we are all working very hard on stopping the pandemic. But we are not doing anything or we are not doing very much to stop the next epidemic. So we must take this opportunity to invest in strengthening the system of community health services. We must again make sure that we have defined what the community health system is. We have defined the components. We have defined the curriculum. We have defined the supervisory

mechanisms. And we have defined the referral system. So until we have that one, the curriculum of training community health workers is very important because it is that community health worker that will help the family through be informed and to do the proper thing.

0:16:13
Miriam Were: What we aim for is to have community norms, community norms that support health. And so the Ministries, the health sector, the Ministries of Health must have the responsibility and must accept the responsibility. To develop a curriculum that ensures that the in community health workers have the information that will help them to promote community norms in our communities. And then once we have trained them, we have to establish systems that supervise them so that they can give continuous services. And we must also have systems within the system, the payment method for the dipo (?) of health, then the since you say you are from Ethiopia, and I know ... (?) are from Ethiopia. I am happy to say that it took place one of those campuses Africa. Well, we are very happy that community health extension workers are on the payroll of the health system because in many countries you hear them called volunteers, how does a woman or a man volunteer seven days a week and a means of support for themselves and their families? So this system must be in place, so we must have an a payment system. We must have a training system. We must have a supervisory system. And we must have a referral process in place. The problem, of course, we know that community health workers cannot deal with every problem. So we must support them in the first level. So in addition to having a community health system, part and parcel of that community health system is the first referral level. What is that firstly referral level? Which health professionals should be there? How many of each type should be there? And are they there? So I always get very sad because the moment you talk about health workers, people talk of hospitals, people talk of but at the most the most expensive hospitals. Hospitals will only need the one we are sick, but we need the system to help you keep us healthy so that we do not overwork, the fewer people working at the health at the hospitals. So sometime and many times, I think I can say in many many countries of Africa, people still see hospitals. I see...(?) health system.

0:18:55
Miriam Were: If you talk about the community, they think you're talking about something irrelevant. And even in urban centers, the informal sector, the informal establishment, the swamps (?) in other words, you go there and you find people are not only ignorant, but they don't even have access to the health facility. I'm this why I really like they took and system. Where are you? There was a rural approach and then an open approach. And if we can have both, I mean, Dr. Omarla (?) the third WHO Director General used to say health is not everything but without help we have nothing. So it is health that should be the first requirement when we are establishing a development system that we must make sure that we establish a ... (?) in a way that there is access everyone has access to the health system and there is quality in that access. So that is why I say that the first process is to establish a curriculum and a process of training community health workers who will empower the community. And the king (?) of we have all the comm... we have defined what a community is. We even have a curriculum, but somehow we don't quite implemented. It is a problem implementing it and I and it is mainly because of the financial allocation. That is very little allocated to the community establishing that the community supports and without that financial supports, financial investment, nothing can work at least two set of we must have this financial and financial investment. And in the African context, we know that our leaders, the head of sets (?), ask that 50 percent of national budget ... to the health sector but less than 50 percent of African country, 15% of them but listen 50% of our African

countries have a great mind will be very very soon very soon. You countries have 15% So we just need to know that without the community health system. We are... Lord help us during an epidemic like as this one.

0:21:16
Miriam Were: They will help a few people one, the rest of us will die. So we have to have a focus on strengthening the community health system, establishing it, and strengthening it, and maintaining it. So, let me stop there and make other marks for if I get a chance.

0:21:38
Seble Frehywot: Thank you so much Professor Were for your wisdom and for concentrating on the community level the workers that work at the community level. Professor Suwit is having some difficulty the moment he joins. I'll give him the mic time. My question is this. So right now with this virus that's moving at the speed of wildfire. What are some practical things that can be done at the community level, by the community, using the community leaders? When we devised this webinar with ACHEST and us, we really tried to reach as many people on the ground, the leaders on the ground, imans on the ground, the priests on the ground, the Buddhist monks on the ground. And the reason being people trust have trust for them. When they speak, people hear them. What are some practical things that can be done with local government leaders on the ground to mitigate this problem on the ground so that the referral health clinics or health centers are not bombarded with so many patients. Dr. Omaswa first and then Professor Miriam Were.

0:23:08
Francis Omaswa: Thank you. And thank you Miriam for that elaborate presentation as usual. So to answer Seble's question, let me give you let me use the Ugandan example of community health system, which is the structure is there it may not be performing as well as we I would like to see it before but it is there and I rather like it. Every village has got an elected political leader. They are piece (?) called local council number one chair. And around him, there is a committee of nine, thirty percent of whom are women and out of that nine, one of them is responsible for health. And it is that person who then works with what is called a Village Health Team? Again, respected members of the community, they are usually women and sometimes young men and that Village Health Team each one of them is allocated homes tests, which they get close to and there is a leader in in work there that leader among the the name makes a map of the village as register it called The Village Health register of every household and monitors who is pregnant, the children in that home are they immunized and the the condition of their health.

0:25:06
Francis Omaswa: Because they know each other they go collect water together and have ceremonies they hold together. So they know each other fairly well. So that system, when it is at its best one of the district's implemented it took to almost to scale, you find that their health facilities are empty layer because it's usually malaria which sends many people to seek help at the nearest health facility and other infections in children, and so on those just disappear immunization coverage levels. And so on even in disease mortality of folks for children and pregnant women went down in that District much more than in other districts. So when you ask what practical steps, that is it, integrating the government, they routine government with the health's a village with the community health workers so that everything works across the road. The water sources are protected. The rural network is

working. The correct foods, it it food stuffs are eaten hygienic practices. And those are our water medium very called norms are being observed. They being applied and in that way, they have a meeting once a month in that way. Then you have a people driven integrated primary healthcare system. But very often, there is a problem with referrals for those who need referrals to higher levels, they very often isolated, don't get the transport or when they reach their they don't get the quality of services that they need. And that disappoints and demoralizes them. And there is also competition with the private sector, the informer health workers, drug shops also traditional healers and so on. But once the general administration of society prioritizes health as well not just looking for people who are opposing the government or collecting taxes, but put health as one of its routine priorities, then we should be on our way to our dream community systems.

0:27:40
Seble Frehywot: Thank you Professor Omaswa. Professor Were?

0:27:46
Miriam Were: Okay, we have a similar system, but we are based on what we call sub-location. It is the smallest administrative unit, but it is made up of several villages. So this application is headed by an assistant chief and other the assistant chief. Communities a number of communities working towards promoting health and what this does is that because it is recognizable in the normal administrative system of the government. It means that it is not news to anybody in terms of what it is. Everybody's part of it and in our case people in the community in each sub-location, they select a Community Health Committee. They select the Community Health Committee which is ... (?) becomes part of the administrators system when they are looking after the community health services. This Community Health Committee and member of the Community Health Committee as the community health worker so that she becomes trained community health worker and she becomes the technical person in the community has committee. And because she's a trained person then their Community Health Committee looks up to her to advise them on issues of health. So this is why it is so important to have a well trained community health worker. In this kind of context then you have what does the community do when I what were some of the things they address is for instance the whole issue of environmental, environmental cleanliness, environmental sanitation. We find because we are many of the many most of upgrades the malarias. We have that when you have very long ... of tall grass and you have got full of water everywhere that encourages the breeding of malaria my breathing of mosquitoes, which makes malaria prominent. For the Community Health Committee, the community health worker helps the committee to make sure that the environment is clean. There are no pools of water, the grass is cut and so on.

0:30:10
Miriam Were: And secondly, in the work that we have been involved in, one of the critical points is to have safe disposal of human waste. There

0:30:20
Miriam Were: is a lot of bush around so it is very easy to ... you to use the bush. But once we understand that there is a connection between using the bush and the quality of the water that you drink taste one of the things that happens very very fast that people begin to build and use that trains. This is a very important because it is not just that if one person who has an apprentice (?) in life, it is not everybody should have because any position to the water will cause illness in our in the majority of

the community. So it is this why it becomes a community norm so that everybody accepted and that's it. Another area that we have seen a big difference in is now one day we hope that Africa will have piped water in our homes in order home. But that's not the reality now. However, we have found that when families are got protector sprays. Protector sprays gives good quality water and if you're good quality water, then that is part of the problem solved. These days because we are having a lot of homes would have got still would have got still still still still roofing (?). They can you can also collect water through this ...(?) collection system and try it safely and bring it close to home and make it viable and clean for drinking water. So these things are very very possible and we have seen then but they are not a hundred percent than and they should be a hundred percent that. And then then you come to the personal health services.

0:32:06
Miriam Were: Where are you do it but according to the life course, you can even begin with a pregnant woman, she give access, she can be looked after right there in the community. She doesn't have to she only go she goes to the health facility at a periodic time, but she's looked after by the community health worker and the same with the babyborn of so that ... the health center for for for for further care when the baby is born, baby is born in a health facility, the community health worker make sure that the baby is born in a health facility and that's appropriate delivery care and delivery support. Then the newborn is looked after and and then from there on you go on into the monitoring of the under five child until the child gets to 5 and so you have a system of care that looks after the first 5 years. And because you are working with a referral system, the other members of the of the community are able to use the first referral system for things that they need if they need if they someone has pneumonia with the community health workder may not be able to teach they can check them refer them their health facility. So if you have a functioning community health system, you can have good environment. You can have clean water you can have use of our training. You can have personal care during pregnancy, during delivery, during a newborn, and during the first 5 years of life and this forms the foundation of a healthy life. And then when you come to the elderly, you also now we are establishing processes for supporting the elderly so that they avoid the decisions of the elderly. The community can also become the basis for lifestyle. Lifestyle changes that promote well-being so we have seen that it works very well if we can just get it to work all the time. Thank you very much.

0:34:06
Seble Frehywot: And thank you so much!

0:34:07
Francis Omaswa: Seble, can I just come in?

0:34:11
Seble Frehywot: Yes, please!

0:34:11
Francis Omaswa: Yeah. Yeah. I'd like to elaborate more on Miriam Were's point about the public knowing that there is a connection between open defecation and what are you drink and under the title health literacy? It is very important that we share with our populations in technical information about keeping healthy. What causes your illness, how can you maintain your inborn health? And that very often is lacking or the wrong information is available to the people. In Africa, for example, one of

the biggest disasters in health literacy is in nutrition. Traditional African diets are very good. They protect you from degenerative cardiovascular disease. Also, they will protect you from diabetes. But our people have now got the impression that our own food is not good, and children are growing up with Kentucky Fried Chicken and McDonald's and oiled and what. So it the correct health promoting information to the people should be one of our top priority through the community health workers, but also through the education system. Many children go to school and in my day is in at least secondary school, there was a subject which you could actually be examined on called health science. That is not there anymore, certainly not in Uganda. Can we advocate for health to become a compulsory? Knowledge issue for learners in all education institutions, particularly children who are young so that by the time they become adults at least they they have this knowledge on their own with themselves. Thank you.

0:36:36
Seble Frehywot: Question and comments are coming before we open up for the discussion as everyone. This is called The People's webinar. We're trying to get wisdom from everybody share this wisdom. But before that, there's something dear to my heart. I want to ask that thing is health care workers even community healthcare workers in this kind of vicious virus that we're facing, we've seen in the past pandemics, the first ones to die are the healthcare workers, but there they are at the community level or at other health service level. So what kind of protection should be given to the healthcare workers at the community level or at the other levels by local governments, by local bodies in order for them to work efficiently their job on the ground and what is lacking right now and what message should be sent to local leaders as well as national as well as international leaders? Professor Were, may I start with you this one and then we'll go to Professor Omaswa?

0:37:35
Miriam Were: Well, we're at what we need to protect our health workers, especially during this pandemic period of course we need to they need to have gloves and they need to have masks and beyond that, we need to give them protective clothing. Now, it becomes a bit of a problem on how to organize this because our ende... pendemic is a problem, but you can you can you can have aprons that are always available to community health workers that they use as a routine piece of their clothes to protect themselves so that when they go home, they take off the apron. The problem is that when you have many times they are not provided with this ... them because they are called volunteers which is a word I really don't like. They are not they don't have the money to buy them themselves. So this is where we need to strengthen the strength it would protect in our system so that we are protecting them while their they're serving the people. Once a salary like everybody else they are given a protective clothing, gloves, and mask so that they can do their job. I don't know if that addresses that you asked.

0:38:56
Seble Frehywot: Professor Omaswa?

0:38:59
Francis Omaswa: Well. Seble, this is a global challenge with COVID. I came to visit my daughter in the UK and then two days before I was due to fly back, they crossed the airport in Uganda. So I'm now stuck here for nearly months and no idea when I go back. But watching the news here, the government of Scotland is fighting with the government of England over protective equipment for for health

workers. They are having to fly them in Charter planes from from China and the message are making is that they say global shortage of personal protective equipment and it is there is a strike of in turns in Uganda now because of personal protective equipment. And of course we need these. Otherwise, we kill the health workers. So step number one first is to educate them so that they know the risks which they faced as health workers and to protect themselves from this as much as possible. They need to have this knowledge themselves and they are of course is now online courses. They say resource material on this. I think we are good some stuff also on the HHS website and COVID and so on so that is number one. And then two improvisation how much improvisation can you do? Some countries are making cloth masks. They if you have nothing at all, it may be better to start with those. But above all all of us all of us, we really need to make a big global fee for effective personal protective equipment for health workers. There is a global shortage. There is also money issues in many of our countries. The government of Uganda for example has made now an appeal to the private sector in Uganda to come forward and put some money on the table for this. So they are shortage of money and also a global shortage of quality protective equipment. So where do we go from here? This is the biggest and worst part of this crisis as we speak now, but to me above all the most important one is for the health workers, community health workers, all the way up to the ceiling, intensive care units to be educated on how to look after themselves. And if necessary not to work if they don't feel safe.

0:42:00
Seble Frehywot: Thank you so much. We went to open it for discussion already questions have been sent to me privately as well as in general to everybody. So if Mona would our first question comes from India, Mona if you can unmute your audio and ask the question.

0:42:22
Mona: Thank you Seble. This is for Professor Miriam. I think you brought such an important issue of paying community health workers. I have been struggling with the whole thing of just internalizing that how can we expect them to be the backbone of our community health system and still consider them as volunteers. My question would be how can we advocate better with the different governments to to put this point forward and can this pandemic like COVID becomes like an opportunity here for us to actively advocate for this so that they become like a proper salaried health workers not being volunteers?

0:43:15
Miriam Were: That is one of the big challenges, I think. We need really to think about that and the more I think about it the more I think that we may need to have at the approach that we took for the Global Fund for HIV and AIDS. We may need to have a global fund established for community health systems. It is the foundation of healthcare and it is the foundation of universal health coverage. So I think we may need to have really to think we need a global fund for community health systems so that we can have a systematic approach which includes including the health worker in the health workforce with payment like they have done in Ethiopia. So you can do it even in a developing country like Ethiopia or a middle income country. So we just I think maybe having a global ... of global fund for community health systems would help us to be an organized and systematic approach to dealing with this issue because each of us talks about it, but we don't have a cons... we don't have a consolidated position because we're not together. We don't have a little aquired for the global fund the global fund has I was working AIDS field and it had really had it has really helped us to focus to consolidate. So maybe we need to have a global fund for community health systems. Thank you.

0:44:43
Seble Frehywot: Professor Omaswa, you have anything to add to this? ... The next question?

0:44:48
Francis Omaswa: Yes. Yes. Yes. Yes very much indeed. It to me the to achieve what Professor Were is asking for? We need to go back to the structures of our health systems. There has been too much lip service on integrated primary healthcare since Alma-Ata but no action to operationalize community health systems. Where community health workers are an integral part of the structure on the health workforce strategy and structures and budget. So maybe this see pandemic can be a new opportunity for us to launch a global campaign on integrated primary health care in which community health workers. An integral part of and on this normal structure of national health workforce programs. So when Miriam Were campaigned before this you've been at this for a long time. Yes. They don't seem to get it when you are just talking about community health workers. But maybe they will get it if we presented with a clear role for them in integrated primary healthcare. They don't ... they need to get the message while community health workers and are they are not alone. They are part of a wider system, but they are the drivers dependence of that system. That is my thoughts on that topic for now.

0:46:47
Seble Frehywot: Thank you. Thank you both. And the next question is Lizzie Lizzie. If you can unmute your mic and then ask the question and people can write their question on the chat box, or they can alert me with their hand so that I can give you the mic to speak. Go ahead, Lizzy.

0:47:10
Lizzie Clark: Hi, thank you all so much for sharing your time and your wisdom. I am curious about what role the community development can play in protecting livelihoods during these times, when a lot of businesses are shut down. I know that a lot of people in low- and middle-income countries may not have the same amount of savings that other countries may have the benefit of or governments that may be able to support them and basic things like getting food during these social distancing times. So what role do you guys see community development played in that?

0:47:55
Seble Frehywot: Professor Omaswa, would you start?

0:47:57
Francis Omaswa: Well, this is this is big. If in compiler for example in Uganda you have big markets and that must apply to all the urban areas. They are big markets run by people who come they being damaged under is there and then they get money on their way back home, they buy milk and food and so on and they live by the day, but with this lockdowns many of those markets have been closed. And those people in very very big trouble. And what I have personally been advocating for is to balance the need for prevention of the pandemic with the need to tip the economies and the livelihoods of people alive. Because there will be more deaths from collateral issues caused by lockdowns than from the Coronavirus. So the livelihoods of people are important and we really can't go on in Uganda. They just extended the lockdown for another three weeks starting yesterday. And therefore I can't go back home or that time, but that is me having that. But what about those people? So I think we should be moving there is a great friend of mine. You, many of you know, Ariel publish Mendez is arguing for us to take

the Sweden example the bifurcated approach of allowing the active young people who are less vulnerable to the virus continue being active. And then advise the vulnerable those with pre-existing conditions and the elderly like us detect more care. So the question of livelihoods and lockdown is one which needs to be discussed further.

0:50:28
Seble Frehywot: Professor Suwit has joined us and Professors Suwit, and the mic is yours to make your fullremarks. Thank you.

0:50:42
Miriam Were: Am I speaking?

0:50:44
Seble Frehywot: No... Yes. Yes. Professor Were, you will speak first and then Professors Suwit would give his remarks.

0:50:52
Miriam Were: I need to mark hat we need to have a balance between the lockdown and the livelihoods. But I think in for us to do that, we need ... I will systematically established process for use of masks masks and physical distancing and then hand-washing with soap. So we need to have the three together. We need to have the three, the hand-washing, the physicial distancing, and and the mask wearing as we release as we as we reduce the lockdown time because even in Kenya super really suffering because many of them depend on on markets and on transporting people they even the transport public was almost coming to a stop and so on. So this is these are all very painful things and we need to balance what we need to balance in a context in which we are also controlling. The COVID that divided the pandemic through use of masks widespread use of masks widespread practice of physical distancing and widespread practice of hand-washing by making a water available water and soap available for people to wash their hands easily without too much trouble. Thank you.

0:52:21
Seble Frehywot: Thank you so much, Professor Were. Professor Suwit come. So as a mic is yours to make your remarks?

0:52:32
Suwit Wibulpolprasert: Thank. Can you hear me well?

0:52:34
Seble Frehywot: Yes, sir.

0:52:35
Suwit Wibulpolprasert: Oh, um, I'm telling myself at home for almost a month now much like Francis in London. Today, we are talking about community health system. And so COVID-19 a pandemic. So I want to focus on that. Community health workers must be be equipped with at least five thing. First, they must be well informed or empowered. Just what that means is what Francis called health literacy, but actually is beyond health literacy empower mean that the need to link to community leaders. They need to have the authorities to do something in their own community. This the first one, empowering

them with knowledge with social capital intellectual capital and linked to authority. Second that you would know what they need to do. Early detection. We in Thailand we call on their community. Who comes in to the community where they're from if they are outside of the community and they at risk do they need qurantine anyone who has abnormal symptom or contact with the infected people. They should be checked the to be qurantine. And if necessary, if it prove that they are infected and hospitals health facilities can accommodate them. Committees would be able to isolate them. This is the second thing that you know, what they can they have to do and they can do. The first thing is they have to be well protected at the community level. I don't think they need full PPE. They're not attending sick patient. Their role should the more on prevention early detection, quarantine, and prevention, advocate for people. To wash their hand, hand hygiene is the most important much more so than the face mask.

0:55:00
Suwit Wibulpolprasert: And I fully agree with Farncis that cross mask is more than enough. Francis, when we are young, we are both surgeons. Do we have surgical masks? No. We all used face masks. After we finished the operation, we washed them till item in reduce again until the face month was torn. Maybe you have forgotten about that. Most young generation surgeon, they don't know they don't know anything about the cross mask. But in my generation, Francis generation, we only have cross mask. We don't have surgical face mask. We don't need a magic face mask at the community level. They don't need PPE suit because we are not taking care of severe case or very closely contact with them. So this is something that we need to understand. These PPE and 95 (?) are very limited in the amount all over the world. So we need to prioritize which we use them. And we need to reduce the demand, even we use them and I reiterate we use them in the medical school in Thailand the sterilize the creating the face mask ultraviolet suit and they use it five times instead of trying to increase supply. You need to reduce the demand as well. That's the third one. They need to be well protected, for funder need to be well motivated not incentivizes not only incentivize incentive mean do keep them position. You give them money, motivation is internal. They feel that they need to do it. They love to do it. They have the passion to do it even without money, even they have to pay money to do it. They want to do it. This is much more important than incentive. Of course, we need incentive. In Thailand, we ...the government doesn't (?) agree to feel 40,000 community health worker from employees to see your servants but we have 1 million village help volunteers, 1 million. Can we all feel them as an employee's? It's impossible. So we continue to advocate for them to be volunteers. You keep them 330 US dollar a month just for traveling to the meeting is not salaried and they don't have other fringe benefit.

0:57:51
Suwit Wibulpolprasert: This other thing that we need, we need to understand and fasting with pandemic like COVID, central government can do something but not that much. It is the local community. In many village in Thailand, they are around (?) now themselves. They love found themselves. They don't allow anyone in or out anyone in will be checked for salary (?). The last point, the fifth point is that these people must not be alone. They have to be linked to local health facilities. They have to be linked to local health facility so that they can get advice, they can refer people. And then this nowadays with the very good Wi-Fi internet. They can use social media to link to a local facility. I'm so glad that you address this issue because we cannot be denied that when pandemic occur, central government is not the answer. It's not the main answer. It is the people, the community that can contribute a lot. I notice that there is one serious roles idea, leader who work very closely with

the community from Thailand, Somporn in the in the in the conference in the meeting. So maybe if you can add more to me. And I'm sorry, I have to leave this meeting to another meeting to the meeting and I would like to sincerely thank whoever may be Francis who started this and please move on. Okay? Thank you so much.

0:59:46
Seble Frehywot: Thank you so much, Professor Suwit.

0:59:47
Francis Omaswa: Good bye, Suwit. Good to say to hear you again.

0:59:54
Suwit Wibulpolprasert: Yeah, keep safe in London, the most dangerous place in the world.

0:59:58
Francis Omaswa: It is that I am housebound.

1:00:04
Seble Frehywot: So we're going to Somporn if you can add what Professor Suwit ...

1:00:25
Seble Frehywot: Somporn is also from Thailand. Go ahead, Somporn.

1:00:29
Somporn Pengkam: Hi everyone. My name Somporn, and I'm from Thailand. I'm a senior fellow of Health Equity Initiative ... East Asia and ... about community low to in the pandemic to about the COVID-19 for me at the first Suwit mentioned about the the key player is not about the central government but local and community is very important. For example in in Thailand, if when the central government has the the skyline about how to deal with the pandemic but many community they have their own their own the skyline to deal with the pandemic, but the problem in Thailand right now, we have some problem and about when will the lockdown end. Many people think the community will be a remote and yeah, maybe have no problem about versatility but in Thailand right now many community they have problem about food security because when you lock down and people can connect each other we have problem of ... didn't really want to to community. But right now in Thailand, the civil society they take action about this. for example in Thailand, we help the NGO and civil society. They were working about the full security issue. They can link with the community that have problem about the the food and they deliver the food to the community.

1:03:12
Seble Frehywot: Thank you so much, Somporn. Important Bjorg? So good to have you and AJ here and there's so much we can learn from both of your wisdom. So the mic is yours, Bjorg.

1:03:24
Bjorg Palsdottir: Good morning to Seble. This is Bjorg. I'm here in ... I just wanted to share with you an experience like the is happening currently in the Philippines. We are working very closely with our partners in the certain part of the Philippine and this experience highlight the importance and the role

that universities can really play in the communities. As you may or may not know, the university is it's called ... are Ateneo de Zamboanga University is when University in the Philippines that is probably the most community-engaged. They their students spend 50% of their clinical training in communities communities that don't have water, electricity. They sleep they live with the people there. The problem with COVID-19 has really been devastating for them. They lost a few of their graduates already and the response that is now being put together is has to to arms if you want. First one is how do you reach the member of these communities to educate them about COVID-19 about the measure that they should take to minimize their risk by the same token how to identify the people were really at higher risk namely people with intercurrent illness like diabetes, hypertension, and so on.

1:05:20
Bjorg Palsdottir: And then the second arm is to manage them, trace them, and the way they came up with his certainly not the way we do here in the US or what is really being done in South Koreans on with apps because you do not really have in many of these settings like in Africa, which many countries in Africa which aren't familiar with. You don't have smart phone. So what do they use its radio, local radio, local TV for those who have the means to have a television but it's free most recent broadcast and how do they set the system? Is that each of these village as what they called Barangay health workers or namely community health workers. And so their community health system is really structured in such a way that each of the Barangay has one of these workers there. And by the way, to connect health workers really easy in the pipeline the administrative pipeline because actually the local mayors really is also involved with them. But what do they do? They really had in the past because of their students and the presence in the community, they have identified years of over the last over the last several actually the last decade the village which they work, they have identified the most vulnerable the a malnourished pregnant women, people with diabetes, people with hypertension, people with asthma, smokers, and so on. So they have very good data set there that the student we're generating with the local health system. So now what do they do with COVID? Is that they really truly radio provide the number of phone number to be called by the people in their communities, but in order not to be flooded, they really provide and phone number of the community health workers responsible for their community.

1:08:01
Bjorg Palsdottir: So that actually that's the first line if you want the first screening and then the community health workers in turn really being trained, turned to the skill. If they don't have the skill turn to actually clinical manager to decide what to do. by doing this, they also not only educate the population but they also are managing cases some people leave, so they request that there is either a significant other or a neighbor who has a phone number who can be reach because if one individual in these communities has been in touch with the community health workers and then suddenly that person disappears from the from the radar screen. You don't know if that person went to health facility, you don't know if that person disappeared. So you have a backup to know what happens by calling the significant other or the neighbors so they are sitting substructure and I think that's very very worth mentioning because also they have not only a system that really provide health education, but they can also manage provide advice and manage the case and trace them. So I just wanted to end, this is actually, ongoing development conference call yesterday again, and it's an ongoing project, but I think it might actually be worth its in very low resource settings. Like we are facing in many countries in Africa or in rural areas, but it is very simple. You don't need a smartphone. That is the main thing

you know just blend simple phone and particularly radio, which many people have this is really a practical practical comment.

1:10:22
Seble Frehywot: Thank you so much Bjorg. For once you've said, yes, it's very practical. I mean wisdom filled and how to also bring the universities and the simple thing of radio and simple forms to build a community systems. There is I'm sure everyone has heard this on this webinar and we'll put it on our websites, also. We take a lot of lessons from that. I want to give the the mic to Joel, Joel, you have a comment and a question?

1:10:58
Joel Bazira: Seble, Dr. Joel from Uganda here in Barara (?). I work at Mariah (?) University. I had an issue with face masks because I think we need to really be clear on. What's the actual role of face masks and who should actually put on a face mask in this time? Because I believe if they are not used properly, they may be a recipe for a bit of more disastor, especially with our people. You find we have people here who ride motorcycles with masks on and emerged as they're going through dust. The mask is dirty. And I think it is to cause more problems than solving problems. The other comment I had is about community engagement and involvement. I believe that when communities are sensitized, they actually take on these issues. We have communities here in Uganda in the southwest where Swahili and they when a woman face to deliver the whole community comes together and they carry this woman, you know as a community responsibility for the hospital. We have neighborhood watches here for security reasons. They use WhatsApp groups. We have ... (?) So, you know all systems where people used to come together to do cleaning of the community the quality of ... (?), I think. That is for the good of the community. So if we can tap into this kind of systems, I believe and bring her health messages. They would be much more impactful than just relying on one, probably one community health person, but involving the whole community raising the community to understand health is is their responsibility and if all of us work together, we solve a problem. I also think that if each of us would understand that if I'm not well the other one is not well that will help us in being able to establish the system at the community level because health begins at home. Thank you so much.

1:13:16
Seble Frehywot: Thank you so much Professor Bazira for that comment. There are things that have been posted on the chat resources and we are going to as I've said put this recording of this webinar on the site and so now we have about 30 minutes left and I want to give the time to Professor Omaswa. Yes, we have to discuss what we need to do at the community level. We have discussed about building the health promotion at the community level, empowering the community healthcare workers at the community level, making sure that they are connected with the leadership so that they can act with power with the community. We have also discussed how to how important it is to empower them with the knowledge with the course of early detection hand hygiene sand or so, but we need also to think of next steps forward. The reason with people like Professor Omaswa who's executive director of ACHEST, we brought this webinar to life is not to just discuss at this webinar but to see what are the steps forward that as a community as a global community, local community, national committee, we can take it forward. A number of ideas have come across and how to take this forward and give the mic time now to Professor Omaswa.

1:14:57

Francis Omaswa: Yeah, it's been a terrific discussion. And I thank everyone who has contributed. The next steps, I would say Seble, is my key takeaway messages. One this community health systems need a movement to advocate for them a global movement to advocate for them. Clarity on what they consist of not just community health workers, but integrated people centered all of society approach which Professor Bazira has yesterday referred to. Then we come then to resourcing them. They should be resourced as part of the national health and governance system. So if we have a campaign that will draw attention to this but that campaign also needs to be backed by evidence. What works how do we know that it actually works? And that evidence is there there is a plenty of it, but we need to put it together so that it is convinced marketed and sold to political leaders. And this is a matter which we will bring up all the way to the World Health Assembly, all the way to the UN General Assembly in the course of time. One of the key witnesses of the global health systems, I think AJ (?) and ... (?) we've talked about this. Can you imagine that in the SDG, Universal Health Coverage indicators? There is no indicator on people participation. In maintaining health, it's not there. The indicators about money and those type of things but and people human resources but not about people themselves. So I have been campaigning for this a birthday proposal for this indicator to be included. I don't know whether it will work. But this is a movement again this group can carry forward. So that this this matter becomes measurable and when it's measurable more action is likely to be taken on it.

1:17:46
Francis Omaswa: Then the technical issues of COVID right now. The professor Were was very good in describing to us what we can do to balance prevention and livelihoods of people. And the issue of face masks. So we need evidence on ... (?) I've seen publication itself on the comparison between the cloth masks and the medical masks. It is true. They are less protecting, but maybe they have a place in public in the market. I did not in the health facilities. So let's not shoot them down altogether and public health measures physical distancing, hand-washing being cleaned and so on will need to be introduced together with to improve the the economies of the countries ensure livelihoods as well as preventing the pandemic. I don't think we can carry on with lockdown for far too long. In Australia has shown an example of not locking down and then of course also winning the trust of the people if you are told to do physical distancing, will they do it? And that again is a communication issue communication will be critical will be critical in get critical communication with the right message by trusted players. And again, that's why this discussion is important. Those are political leaders at the local level, the cultural leaders, the religious leaders all part of this webinar and together it it will be those community health systems ... (?) our colleagues from Thailand, same. That is its local not national that will win this battle. So thank you very much indeed.

1:19:58
Seble Frehywot: Thank you. Doctor Omaswa. So we're nearing at the end. We have posted for you, ACHEST website within the within the chat box as well as on the registration website have posted for you IT fHESE health system education system equity website also. So only one pebble can cause so much ripple effects in an ocean. More than 80 great global leaders have registered for this website for this webinar. They some of them were not able to join, but plan to hear what has been discussed today. These are people that have invested their lives for the cause of the community. So I'll take if there's any one or two comments at the end. Anyone wants to make please raise your hand. Otherwise, I want to thank I want to thank the presenters the speakers or so. I'll just give one second if there's anybody who wants to unmute themselves and speak or give time for that now.

1:21:17
Seble Frehywot: I don't see any hands. So thank you so much for Professor Omaswa, Professor Were, as well as Professor Suwit, as well as for each and every person that made a contribution today by being here by sharing your wisdom. And let's see. There are more than 80 people on this webinar and let's see how we can move forward this again. ACHEST website is we have put it in our chat box as well as it is on the website where you all have registered. Thank you so much. We are having another webinar on as you know, the mental health of many people is being affected and the invisible disability that is taking lives through this crisis, even when this crisis was not over so we're going also to concentrate on that. So saying that I I'm going to close this webinar and then mental health disability webinar is going to be on April 30th. But before that I'm sure we'll have more discussions on this with leadership of Professor Omaswa. Thank you everyone, good evening, good morning as well as good afternoon.

1:22:48
Francis Omaswa: Okay. Bye. Keep safe.