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Social multiplier effects: Academics' and practitioners' perspective on the benefits of a tuberculosis operational research capacity-building program in Indonesia

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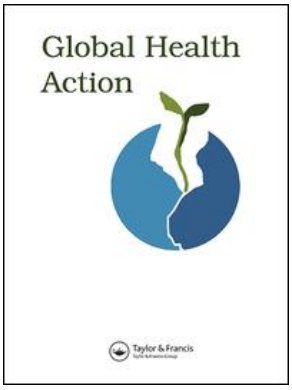

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Global Health Action, Volume 10, Issue 1

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Original Article

Article

Global nursing in an Ebola viral haemorrhagic fever outbreak: before, during and after deployment

Eva von Strauss, Stéphanie Paillard-Borg, Jessica Holmgren & Panu Saaristo

Article: 1371427

Published online: 10 Oct 2017

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Article

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Amber Mehmood, Edward Chan, Katharine Allen, Ammar Al-Kashmiri, Ali Al-Busaidi, Jehan Al-Abri, Mohamed Al-Yazidi, Abdullah Al-Maniri & Adnan A. Hyder

Article: 1380360

Published online: 13 Oct 2017

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Article

Social multiplier effects: academics' and practitioners' perspective on the benefits of a tuberculosis operational research capacity-building program in Indonesia

Ari Probandari, Yodi Mahendradhata, Bagoes Widjanarko, Bachti Alisjahbana & On behalf of Tuberculosis Operational Research Group (TORG)

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REVIEW ARTICLE

OPEN ACCESS

Who is a community health worker? – a systematic review of definitions

Abimbola Olaniran, Helen Smith, Regine Unkels, Sarah Bar-Zeev and Nynke van den Broek

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ABSTRACT

Background: Community health workers (CHWs) can play vital roles in increasing coverage of basic health services. However, there is a need for a systematic categorisation of CHWs that will aid common understanding among policy makers, programme planners, and researchers.

Objective: To identify the common themes in the definitions and descriptions of CHWs that will aid delineation within this cadre and distinguish CHWs from other healthcare providers.

Design: A systematic review of peer-reviewed papers and grey literature.

Results: We identified 119 papers that provided definitions of CHWs in 25 countries across 7 regions. The review shows CHWs as paraprofessionals or lay individuals with an in-depth understanding of the community culture and language, have received standardised job-related training of a shorter duration than health professionals, and their primary goal is to provide culturally appropriate health services to the community. CHWs can be categorised into three groups by education and pre-service training. These are lay health workers (individuals with little or no formal education who undergo a few days to a few weeks of informal training), level 1 paraprofessionals (individuals with some form of secondary education and subsequent informal training), and level 2 paraprofessionals (individuals with some form of secondary education and subsequent formal training lasting a few months to more than a year). Lay health workers tend to provide basic health services as unpaid volunteers while level 1 paraprofessionals often receive an allowance and level 2 paraprofessionals tend to be salaried.

Conclusions: This review provides a categorisation of CHWs that may be useful for health policy formulation, programme planning, and research.

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KEYWORDS
Lay health worker; health workforce; role; scope of practice

Background

To achieve the health-related Sustainable Development Goals (SDGs) and universal health coverage (UHC) in the post-2015 period, adequate numbers of competent health workers are required to provide services in an enabling environment [1]. A decade ago, the World Health Organization (WHO) declared a crisis in the global health workforce, characterised by severe shortages, inappropriate skill mixes, and gaps in service coverage [2]. The magnitude of the health workforce shortage varies across contexts with rural regions and low- and middle-income countries being the worst affected, and with critical shortages greatest in sub-Saharan Africa [3].

Evidence suggests that the presence of community health workers (CHWs) can complement an overstretched health workforce and may be key to increasing the availability of, and access to, basic health services especially in hard-to-reach areas, thereby bridging the health equity gap [4,5]. However, the diversity of roles and inconsistent nomenclature of CHWs make it difficult for policy makers, programme planners, and researchers working with CHWs in different settings to have a common understanding of 'who is a CHW?' [6]. Furthermore, in contrast to professional health workers, there is remarkable diversity in the content and duration of CHWs' training. Some CHWs undergo informal training, with varied training content and durations, taking place outside recognised training institutions. Other CHWs undergo formal training in nationally recognised training institutions with structured training content and duration [7,8].

There have been different attempts to define and categorise CHWs based on their roles, educational level, and remuneration [5,9]. However, there is a need to build on these approaches by using a methodical approach that accommodates the diversities in CHW definitions to identify the spectrum of CHW categories that will aid comparison with other groups of health workers. Health worker categories that are comparable across disciplines may be crucial to designing CHW roles and positions within multidisciplinary health teams [10].

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REVIEW ARTICLE

OPEN ACCESS

Diabetes and pulmonary tuberculosis: a global overview with special focus on the situation in Asian countries with high TB-DM burden

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ABSTRACT

Background: The double burden of tuberculosis (TB) and diabetes mellitus (DM) is hitting certain Asian countries harder than other areas. In a global estimate, 15% of all TB cases could be attributable to DM, with 40% of those cases coming from India and China. Many other countries of South, East, and South-East Asia are of particular concern given their TB burdens, large projected increases in DM prevalence, and population size.

Objective: In this narrative review, we aimed to: (i) give an overall insight into the evidence on TB-DM epidemiology from high double burden Asian countries, (ii) present the evidence on bi-directional screening implementation in this region, (iii) discuss possible factors related to higher TB susceptibility of Asian diabetic patients, and (iv) identify TB-DM comorbidity treatment challenges.

Methods: The PubMed and Google Scholar databases were searched for all studies addressing DM/TB epidemiology, bi-directional screening and management in South, East and South-East Asia.

Results: We identified the DM prevalences among TB patients as ranging from approximately 5% to more than 50%, whereas TB prevalences among diabetic patients were 1.8–9.5 times higher than in the general population in developing Asian countries. Evidence from studies designed to address diagnosis and treatment of the dual disease in these critical regions is scarce as well as the evidence related to possible DM patients' genetic and acquired predisposition for TB.

Conclusion: More prospective studies specifically designed to address adequate screening techniques, identify patients at risk, and define an adequate treatment of dual disease in this region are needed without delay.

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Ari Probandari, Sebelas Maret University, Indonesia

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Asia; bi-directional screening; diabetes–tuberculosis prevalence; treatment challenges; tuberculosis susceptibility

Background

Diabetes mellitus (DM) is a serious lifelong disease that has been increasing in prevalence year after year. In 2012 alone, it caused 1.5 million deaths worldwide. The global prevalence has risen from 4.7% to 8.5% since the 1980s, and it was estimated that 422 million of adults were living with DM in 2014 [1]. This increase has been due to the accelerated rise of DM in low- and middle-income countries rather than in high-income countries [1]. By 2030, it is estimated that approximately 552 million people will be affected by the disease [1]. A national survey study from 2007 to 2008 reported that DM had reached epidemic proportions in China with a prevalence of 9.7% [2].

In contrast to DM, tuberculosis (TB) incidence has been decreasing by an average of 1.5% per year since 2000, to a current level 18% lower than the incidence reported in 2000. However, TB remains one of the world's biggest threats. In 2014 alone, 1.5 million people died from TB and another 9.6 million are speculated to have fallen sick [3]. Of these, Indonesia and China had the largest number of cases [3]. In addition, there is an even more unsettling problem – multidrug-resistant TB (MDR-TB). These statistics, along with worsening of TB through comorbidities such as HIV and DM, jeopardize the global objective of ending TB by 2030 and achieving its elimination by 2050 [3,4].

Worldwide, there are an estimated 9.6 million new patients with active TB annually [3] and of them, 1 million have both TB and DM (TB-DM) [5]. In the current scenario, the number of patients with TB-DM comorbidity is higher than the number of patients with TB-HIV co-infection around the world [6]. This is extremely worrying, as highlighted in a review by Harries et al.:

> The response to the growing HIV-associated TB epidemic in the 1980s and 1990s was slow and uncoordinated, despite clearly articulated warnings about the scale of the forthcoming problem. We must not make the same mistake with diabetes and TB [7].

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REVIEW ARTICLE

OPEN ACCESS

The potential for political leadership in HIV/AIDS communication campaigns in Sub-Saharan Africa

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ABSTRACT

Background: The HIV/AIDS epidemic has become a point of important political concern for governments especially in Sub-Saharan Africa. Clinical and public health interventions to curb the epidemic can be greatly enhanced with the strategic support of political leaders.

Objective: We analyzed the role of national political leadership in large-scale HIV/AIDS communications campaigns in 14 countries in Sub-Saharan Africa.

Methods: We primarily reviewed grey and white literature published from 2005–2014. We further triangulated data from in-person and phone interviews with key public health figures.

Results: A number of themes emerged supporting political leaders' efforts toward HIV/AIDS program improvement, including direct involvement of public officials in campaign spearheading, the acknowledgment of personal relationship to the HIV epidemic, and public testing and disclosure of HIV status. Areas for future improvement were also identified, including the need for more directed messaging, increased transparency both nationally and internationally and the reduction of stigmatizing messaging from leaders.

Conclusions: The political system has a large role to play within the healthcare system, particularly for HIV/AIDS. This partnership between politics and the health must continue to strengthen and be leveraged to effect major change in behaviors and attitudes across Sub-Saharan Africa.

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Maria Nilsson, Umeå University, Sweden

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Political leadership; HIV/AIDS; Sub-Saharan Africa

Background

Political leadership is a critical pillar of a country's healthcare system with great potential for impact. Political leaders have the opportunity not only to develop or improve the health system by drafting and passing bills, but also to use their inherent influence on the public to improve health attitudes and beliefs. Unfortunately, we have limited data within the public health field on how political leaders influence health outcomes.

The HIV epidemic is a prime example of the opportunity for political leadership to fundamentally redirect health attitudes and possibly, as a result, behaviors among a population. Since the beginning of the HIV epidemic, important factors relating to the growth of the epidemic have centered on people's sexual choices (e.g. number of total lifetime partners, number of concurrent sexual partners, duration of time between new partners, age of sexual debut, use of condoms or other protective measures, type of sexual intercourse). These choices are influenced in large part by individual decision-making, societal norms and expectations, cultural context, and subsequent consequences including health outcomes, but also legal and economic repercussions. The political system, particularly through elected officials such as the President and Prime Minister, can also have an influence on people's knowledge and attitudes with regard to HIV transmission. However, there is limited data on the way in which various countries have utilized their political systems to promote aspects of national public health responses to HIV.

Given that the HIV epidemic is heavily concentrated in Sub-Saharan Africa, a region with a history of political instability, it is especially important to study the role of political leadership within Sub-Saharan African countries. Case studies comparing various leadership decisions and ideologies in Sub-Saharan Africa have reflected the importance of high-level leadership, including that of the President, Vice President, First Lady, Ministers of Health, Prime Ministers, international Ambassadors, and other figures of political influence [1–3]. While it is essential to broadly acknowledge that political leadership is relevant to health outcomes, it is perhaps more useful to specify distinctive avenues through which politicians can impact healthcare. A study by Noar et al. focused on national HIV campaigns in Sub-Saharan Africa, North America, and Western Europe, many of which were started by country governments, and found that several campaigns have resulted in improvements in intention to change behavior and self-reported behavior change, as well as increased

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