THINKMD™

GLOBAL HEALTH OPEN MIC VIRTUAL EVENT

Key Takeaways: September 2022

Overview

THINKMD hosted a Global Health Open Mic event on 15 September for stakeholders in global health to share their pathways to digital adoption. It was emceed by Bobby Jefferson, Global Head of Diversity, Equity, Engagement and Inclusion (DEEI) and formerly the Chief Technology Officer for DAI Global Health.

Pathways to digital health adoption

DAI
Shaping a more livable world.

The pathway to digital health implementation is far from clear for decision-makers charged with rolling it out in their health systems. Global health stakeholders were invited to share five minutes of insight into their digital health adoption journey, what worked and what didn't, challenges and what is needed for a more seamless transition.

Open Mic Event

THINKMD will be hosting a series of opportunities to provide an accessible platform for global health dialogue, in the form of Virtual Open MIC events.

No long presentations, no text-heavy slides; this is short, sharp and to the point with expertise and thought leadership at the forefront. This is a forum for all voices on important and challenging global health topics, from the individual beneficiaries and frontline health workers to the content experts and leaders. THINKMD's role? Simply to help facilitate dialogue.

Have feedback on our Open Mic?

2022 Open Mic Speakers

A range of stakeholders from across the globe joined us to share their insights and experiences.

Open Mic Speaker 1

Angel Chelwa

Zambia

Vice President of Operations,
Healthy Learners

Open Mic Speaker 2

Prossie Muyingo

Uganda

Community Health Worker, Ministry of Health Uganda, supported by Living Goods

Open Mic Speaker 3

Dr Sarah Kiptinness

Kenya

Head of Medical Services, Penda Health

Open Mic Speaker 4

Sebastien Osterrieth

Togo

Monitoring & Evaluation Associate for Integrate Health

Open Mic Speaker 5

Darlene Irby

USA

Executive Director, Digital Health, Pathfinder International

Key takeaways from the 2022 Open Mic Speakers

Key takeaways: Angel Chelwa

- The Healthy Learners school-based program entails training teachers to be school health workers so that they can identify, screen, potentially treat and refer learners to healthcare facilities within their catchment area.
- Up until 2019 most of this work was done on paper. Teachers would follow guidelines on paper and based on their recall from their training. Then they'd fill out other documentation to track or enter data on how they were performing, or on screenings and assessments that they had gone through.
- This was laborious both for the teachers and for any kind of process that required reporting or tracking, or giving back any feedback on how the program was being implemented and how it was faring, especially back to our partners in Ministry of Health and Education.
- In 2019, we started transitioning onto a digital platform. This was necessitated by the need to have better access to the data of the program and how it was being implemented, as well as ensuring that there was quality in the service provision and make it easier for the teachers to do their work.
- We rolled out the new diagnostic tool, so teachers could screen, assess and treat learners based off a diagnostic algorithm that provides recommendations for potential diagnoses as well as for referral where necessary.
- Since 2019 we've been able to collect quite a bit of data and last year, we signed an MoU with the government to roll out and scale up this program from just 40 schools in Lusaka to over 500 as of last week, reaching almost 500,000 learners in Zambia.
- **This would've been quite impossible with paper.**
- What has really been phenomenal about this transition is teachers feel more comfortable. They're more confident about the decisions they make.
- It's also improved the linkages between the health facility and the learners, because the clinical guidelines, that the application uses are in line with WHO guidelines and our local treatment guidelines.

Key takeaways: Prossie Muyingo

- Digital health has been rolled through a of Community Health Workers
- The tool we use can give the diagnosis and the right treatment options, counseling and family planning. It can help us refer those who need long-term family planning, as well as send out health reminders.
- It simplifies our work and makes it faster, more efficient and allows for a quality and timely data collection.
- The challenge that have with the tool is access. Digital tools often require smartphones, but not every CHW has one. We also may lack knowledge on how these phones operate and the money to buy daily internet.
- In some areas there is no network for internet. So CHWs must travel to find good internet.
- There is an online course we did, which helped us to communicate with the other CHWs worldwide. Now there is a group of more than 35 speakers, we call it a bureau of speakers. And we have the Advocate WhatsApp group and Viber group, which accommodates 400 CHWs worldwide.
- When I joined the Advocacy group in 2020, the beginning of the COVID-19 pandemic, I get a lot of help from my fellow CHWs worldwide. I use the knowledge that I get from them to help my fellows in my country. Now, I oversee more than 10 CHWs.
- When I get information from that group, I share it with these CHWs. We can sit and talk about how are we going to help the community. We decide it together.

Bobby Jefferson

"This shows the power of digital health, when it is adopted, you have an opportunity to leverage and use CHWs worldwide, including those who are in other countries and their experiences. You can apply different practices and see if they would work for you."

Key takeaways: Dr Sarah Kiptinness

- Penda Health is a group of 19 medical centers. We see about 30,000 patients per month across these medical centers. We have a medical staff of about 380. 80 of them are clinicians.
- One challenge we face at Penda is being able to standardize the care given across all 19 medical centers, from all our different clinicians with different backgrounds and training and different levels of experience. We also want to ensure that, even as we standardize our care, that we're giving quality care and we can measure the quality of the care we are giving.
- In order to address, one of the tools we came up with is a clinical decision support tool, CDSS, which is basically an EMR-embedded system that helps direct and support our clinicians at the point of care in building their diagnosis from clinical compliance and supporting them with evidence-based recommendations.
- **It’s like what Uber did to the taxi driver. Our CDSS is guiding our clinicians to the appropriate diagnosis as fast as possible. It's not showing them how to drive. It's not showing them what to do. But just guiding and supporting them towards an appropriate diagnosis and giving the appropriate care. But the clinical decision and ability to encounter the patient and integrate that and use their medical knowledge is still all up to them.**
- The clinician will then decide on the diagnosis. When they key in that diagnosis, a pop-up appears with the appropriate evidence-based medication for that diagnosis, based on WHO and Ministry of Health in Kenya's recommendations.
- We started this project in March 2021. Now 90% of the diagnosis we see in our outpatient department had some form of CDSS support, that's chief complaints and diagnosis. Our goal was to get 85-90% adherence to these guidelines.
- It took a lot of buy-in from our clinicians. Many initially felt like they didn’t need this type of guidance.

Key takeaways: Dr Sarah Kiptinness

- We have Ministry of Health PDF documents that you can pull up and look at. We have all these different guidelines in separate spaces that you can access. But you can't access them at the point of care and that's when you really need them.
- We have brought those guidelines closer to the clinician to help them make the right decision and support them. This is just guidance; we are not taking over their clinical decision.
- Healthcare providers will often say, "We offer quality healthcare." But we've never been able to measure this. **Now we know we have 90% adherence to evidence-based WHO guidelines and MOH guidelines because we have that data.**
- We needed feedback from our providers, but we also needed feedback from our patients. In terms of patients, because we already had an EMR since 2016, they didn't really feel the difference of an additional tool. However, we have seen our Net Promoter Score (NPS) steadily rise.
- **One thing we realized was the most important value for a patient in terms of quality care was not being given the correct medication, it’s about “You saw me, you heard me, you asked me all the appropriate questions and I felt that you treated me well."**
- We had to make sure the tool isn't too overwhelming for providers so that it distracts them from “seeing” the patient. At the very beginning we did see our patients feeling disconnected from their providers because they were spending a little extra time on their laptops. We had to make the tool a bit more user-friendly for the providers. We also had to receive a lot of feedback on how to make it easier for them to get to the patients.

Key takeaways: Sebastien Osterrieth

- I work for Integrate Health. We are mainly based in North Togo and our mission is to make primary healthcare accessible to all.
- We have different components in our approach to achieve that. But the most relevant for our topic today is our 200 full-time community health workers that we digitized just a few years ago. They provide home-based care, day-to-day, to more than 200,000 people.
- Our journey in digital health started in 2014. We had a MIT intern that came and just suggested to use Comcare. That was the first tool that we tried. It was convenient because the person knew that tool and we had no idea, so we gave it a try.
- Later on, we had exchange visits with the NGO Muso that was working in community health in Mali. There we discovered Medic Mobile.
- Those two examples show you how we choose our tools; it's just hearing about them and seeing them in a professional context in our professional network.
- Just like that, we were trying six different digital health tool and most of them are still deployed on the field right now. We think we have a fair understanding of what to expect from those and what obstacle we faced, which are different for each tool.
- The benefits for the health worker include the decreased paper load with everything now configured in these tools, the clinical guidance which helps them with step-by-step diagnosis, treatment recommendations and referrals, and help with their day-to-day tasks if the tool enables some feature a like patient registry or a task reminder. They can also receive better customized feedback because the tool can better track individual performance than the paper was doing before.
- In the office, we noticed a very high improvement of the data quality. It saves a ton of time on data entry because you are decentralizing the data entry from the office to the field, so the office team can spend way more time investigating the data instead of just entering it.

Key takeaways: Sebastien Osterrieth

- Overall, the data is more reliable, available faster and bring more insights to more people. This helps us provide better care to the patient, which is always our ultimate goal.
- On the challenges side, you need electricity, you need internet to make all this work and it's not available everywhere. We also have a very high device turnover. It's difficult for us to identify the patient because there is no unique patient ID system in place in the country.
- In terms of the technology itself, a challenge is interoperability. When you have so many apps deployed at the same time, it’s difficult to make them communicate with each other.
- **During our journey, we also realized that no tool does everything. For years, we have been chasing the perfect dream app and, sadly, it does not exist. Each tool has its own strengths, weaknesses, features and we must build around that.**
- The last obstacle, is the lack of leadership globally within the government stakeholder. There is no formalized digital health strategy.
- For easier digital health adoption, there should be less tools available. There are so many and it's overwhelming when you are an NGO and you try to start finding your way in this world. We need a restrained number of open-source tools that are universally recognized and backed by the biggest stakeholders.
- We need to map all existing tools and collaborations with tech producers.

Bobby Jefferson:
“How would you go about selecting or choosing a tool based on requirements by the community health worker?”

Sébastien Osterrieth:

- This is a thing that is often not well done at the beginning. There are a lot of top-down decisions that are made, where a stakeholder decides they are going to try a tool and the CHW must deal with it.
- This is one of the reasons why we have so many tools. CHWs like different tool or different features, so we don't want to take them away from the tool they are using right now and give them something else because they like each tool for their own feature.
- We've been doing focus groups. When we all sit together and we ask, for example, "Tell us, each of you tell us three things you like about your tool and three things you don't like." Then you begin a conversation and hear feedback, which helps us understand which features they like the most.

Key takeaways: Darlene Irby

- I've worked in the field of digital health for about 17 years.
- Pathfinder implements sexual reproductive health climate and women-led climate resilience, HIV and women empowerment programs globally. At Pathfinder, I'm responsible for digital strategy, digital transformation and digital implementation across all global programs.
- **We're hearing about cutting edge analytics, artificial intelligence, machine learning, end user feedback, statistics, analytics. Yet, out of a nearly 100,000 tools in 2015, a study showed that only 7% of them were really estimated to be focused on women's health. A lot of the tools that we have really don't dig deep enough and really focus on the importance of women and children and, to some extent, adolescence globally.**
- Here are some of my key lessons:
- It's hard for us technologists to really acknowledge that developing the technology sometimes is the easy part. The challenge is building the infrastructure around to ensure that the tool; the laws, the policies have a capacity really supports the tool that we're developing. We need to, when we develop solutions, think about the frameworks that address fairness, equity and digital security from the start.
- A lot of the tools that we've created are really focused on just grabbing data. That data needs to inform health access, health quality and focus on really improving the lives that we intend to interact with.
- We need to give attention to if and how digital interventions address or exacerbate inequalities, health dynamics, health gaps and problems with health system strengthening. We need to make sure that when we develop relevant tools that can positively impact those populations we intend to engage with.

Key takeaways: Darlene Irby

- What is is needed for a more seamless transition going forward:
- Technology should be based on what's already in use. We don't need to create new systems. Sometimes we create new systems and tools just for the sake of innovation. We should take a different approach and really talk about a recycle and an upcycle mentality, informed by what's happening on the ground, meeting countries, health systems and healthcare workers where they're at. We have these great smartphones but a lot of times there's no internet access and people can't use them.
- We still have this siloed approach, and it is impacting how we deliver health and other services across some of the areas in which we work. We need to think about health systems and realize that health systems that are siloed don't really support a holistic approach to health.
- Finally, and most importantly, what is created must be sustainable. A lot of times in our work, we create systems, we use smartphones and then it's donor dependent and then it disappears when the project is over.
- I really have come to believe that if a technology is institutionalized by those who it's intended to serve and provide services to, then it's more likely to be embedded into local policies for the long-term and not the short-term. I think when we design, we need to really keep sustainability in mind if we want our digital health interventions to live as long or outlive the project.

Q&A: Digital health tools beyond health

Bobby Jefferson:

Has Healthy Learners been able to establish a link between the digital clinical tools being used and the improved educational outcomes of students or at the country level? So, you're using it for health, but is there a link to be able to associate that with education?

Angel Chelwa:

- Some of the evidence that we've been able to collect shows that from the start of the program to about maybe three months ago, the percentage of learners who are seen within 24 hours of them being sick has improved by 15%. Additionally, they come in and see the teacher and speak to the teacher, so the trend is that learners are being seen earlier as soon as there's an onset of symptoms. This means the amount of time that learners are spending at home, or in the hospital, or away from the school has significantly reduced since we started to collect this data through this tool.
- We've also seen that 93% of learners who are seen at the school and referred to a health facility come back into school within three days of them falling ill.
- Anecdotally, teachers will tell us that their learners used to be more afraid of seeing the health teacher, but now they're excited to see them. They're more open about the health conditions they're facing. Just last week I was in Choma, in Southern Province and one of the head teachers was telling us about how the number of teenage pregnancies that they've been experiencing from their learners, or that they've seen from their learners, has reduced drastically. This past year they have not experienced any pregnancies.
- By and large, children are staying in school, which is one of the highest indicators for educational outcomes.

Participant comments

“What we've sort of seen is that the COVID-19 pandemic has shown that many people from around the globe really have a desire to be more active participants in managing their health journeys. For instance, the proliferation of self-testing as a form of self-care was really widely adopted in many geographies and many others will be joining the movement soon. We see that there's still ministries of health and such that are adding self-testing into their toolbox. Really, just the need for individuals, communities and local governments to be aware of current disease prevalence just continues beyond COVID-19 to other illnesses including malaria, HIV and others.”

– Shawna Cooper, Audere

“It's really cool to hear what Healthy Learners is doing in Zambia. It’s exciting to see how we can create linkages. Because, as you heard, if children are healthy and families are healthy, they're more likely to stay in school versus dropping out. I would love to discuss how to connect the two industries together better.”

– Dawne Walker, the Palladium Group

Resources

Access resources on Digital Health Implementation & Planning.

Resources

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Interested in having your say next time, or have questions or suggestions for the next Open MIC theme?

Email thinkmd@thinkmd.org