Mini Review
Volume 7:12, 2022

International Journal of Public Health & Safety

ISSN: 2736-6189 Open Access

Intervention Program to Support Community Health Workers' Mental Health

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Abstract

Participants identified the need for a hub for coordinating CHW activities, a care coordination team to manage their health, training programs aimed at improving their work performance and taking control of their health, a communication system that keeps them in touch with colleagues, family, and the communities they serve. They cautioned against confidentiality breaches while handling personal health information and favoured tailoring interventions to the unique needs of CHWs. Participants also advised on the need to ensure job security for CHWs and draw on available resources in the community. To measure the impact of such an intervention package, participants encouraged the use of mixed methods and a co-designed approach.

Keywords: Mental health • Community health workers • Faces challenges

Introduction

As the COVID-19 pandemic continues, there is an increasing reliance on Community Health Workers (CHWs) to achieve its control especially in low, and middle-income countries (LMICs). An increase in the demand for their services and the challenges they already face make them prone to mental health illness. Therefore, there is a need to further support the mental health and well-being of CHWs during the COVID-19 pandemic. We organised a workshop on Zoom to deliberate on relevant components of an intervention package for supporting the mental health of CHWs in LMICs during the COVID-19 pandemic. We used a thematic analysis approach to summarise deliberations from this workshop [1].

The COVID-19 pandemic has placed much stress on health systems worldwide and impacted the mental health of health care professionals. This is especially true for low, and middle-income countries (LMICs) facing critical shortage of health professionals. As the number of those affected by COVID-19 increases worldwide, governments in several countries involve Community Health Workers (CHWs) in efforts aimed at controlling the pandemic. CHWs are in turn confronted with stigmatisation from local communities in which they live and work, who fear that the health workers could spread the infection. They are also confronted with an enormous caseload, a mounting patient death toll, shortages in Personal Protective Equipment (PPE), and uncertainty about best treatment options. Particularly in LMICs, CHWs are disproportionately female, and many must confront these challenges while managing family responsibilities and paid work. These factors put them at increased risk of developing psychological distress and mental health symptoms [2].

Previous studies have described efforts to support the mental health and well-being of health workers (including CHWs) during the COVID-19 pandemic. These efforts include ensuring safe working conditions, providing psychological support, training, and adequate remuneration. In view of the fact that many LMICs struggle with health worker shortages and rely on CHWs to provide health service, our team conducted a survey (between 25 May and 8 June 2020) to explore a) the mental health burden of CHWs in LMICs during the pandemic; b) what services, if any, had been designed by the organisations that employ CHWs to support their mental health. We received 74 complete responses from 61 unique organisations/institutions (including government and non-government organisations and research institutions working with CHWs) in India, Kenya, Peru, Bangladesh, Ethiopia, Nepal, the Philippines, and South Africa [3].

Survey respondents included primary care doctors, heads of institutions (e.g., NGOs), program managers, project implementers. Of these, 57·4% of the participants stated that their organisations had noticed mental health symptoms among CHWs working with them. These included core mental health symptoms such as anxiety and depression (76.5%), undifferentiated symptoms such as fatigue and somatisation (70.5%), and complaints of high workload and burnout 14.8%). Fortunately, about half of all the institutions/organisations (55%) had developed training modules and made provisions to support CHWs' mental health through the provision of psychosocial support on WhatsApp, peer groups (61.3%) and pharmacotherapy (9.7%). However, a lack of robust evaluation data, and a relative lack of implementation evidence outside of India (where 44% of the identified interventions were offered), highlights the need for more research to create scalable mental health solutions for CHWs [4].

Discussion

Given that workshops can serve as avenues for design innovation, learning, and as a qualitative research method for generating reliable data, we planned one workshop comprised of stakeholders involved in promoting CHW mental health. Due to international travel restrictions put in place globally to prevent the spread of COVID-19, the workshop was held virtually. This paper summarises stakeholders' views from this virtual workshop. It provides insights on the core components of an intervention package for supporting the mental health of CHWs in LMICs during the COVID-19 pandemic, how the uptake of such a package might be supported, and how its effectiveness might be assessed [5].

Conclusion

The participants described five components of a support package for CHWs: a hub, a care coordination team, a communication system, training programs, and improvements linked to increased job security and respect

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Received: 01 December 2022, Manuscript No. IJPHS-22-86025; **Editor assigned:** 03 December, 2022, PreQC No. P-86025; **Reviewed:** 15 December 2022, QC No. Q-86025; **Revised:** 21 December 2022, Manuscript No. R-86025; **Published:** 28 December, 2022, DOI: 10.37421/2736-6189.2022.7.314

for the position. Participants noted that each of these components must be gender-sensitive or responsive to the different needs and preferences of male and female CHWs. These components are further described as follows: Realising that modifiable risk factors for physical and mental health conditions often co-exist; participants identified the need to protect both the physical and mental health of CHWs during the COVID-19 pandemic. They opined that this would require the services of a multi-disciplinary medical team responsible for routine (physical and mental) health checks for CHWs. They also advocated for the role of non-medical personnel (e.g., community leaders, hospital chaplains) and non-governmental organisations (NGOs) who would provide psychosocial support to CHWs during the pandemic. In addition, peer navigators were proposed to help CHWs navigate these resources. The participants discouraged setting up care systems outside existing hospital and community systems and advocated for continuity of care coordination teams beyond the COVID-19 pandemic. Participants also mentioned the need for a communication system paid for by the hospital/health facility where CHWs work. This communication could include text messaging services, phone calls, or video conferencing to send messages of encouragement to CHWs during the pandemic, maintain regular communication with other members of the health team and their families, and provide up-to-date health information.

Acknowledgement

None.

Conflict of Interest

None.

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How to cite this article: Coetzer, Jessica. “Intervention Program to Support Community Health Workers' Mental Health.” Int J Pub Health Safety 7 (2022): 314.