Greetings Chairman Lee and Members of the Senate Human Services Committee.

My name is Nada Soliman, and I am a Master of Public Health Students at North Dakota State University, Fargo.

I write to you this morning in support of the HCR 3015, which requests a study of how community health workers could expand access to health care in North Dakota, reduce healthcare costs and improve health outcomes for North Dakotans.

The scope of work of a Community Health Worker (CHW) varies based on state regulations and parent organization policy. Examples of work Community Health Workers can do includes home visiting, first aid, health education, chronic infectious disease prevention and management, maternal and child health services, provision of water and food and behavioral health support, to name a few. In fact, Health Workers are skilled front line healthcare personnel recruited from the communities and trained to serve as additions of health care services.

Many studies worldwide proved the effectiveness and impact of CHW programs countless times, demonstrating that task sharing in healthcare is a successful strategy with which to approach global health goals. For example, in Egypt, (my birthplace) CHW program has been developed in 1964 and ran by various government ministries proved very effective in family planning (FP) education and promotion, promotion of vaccination, postnatal care, health education and Community development projects (Collecting demographic data for catchment area and Record keeping). In 1995, 87% of CHW lived in the same community that they served. CHW training, supervision and payment proved to be very feasible and can be tailored to the job assigned to them in their local communities.

In addition, CHW programs appear to be increasingly important in achieving health and development goals in the years to come. Countries can benefit greatly from. These successful programs and models to improve the health of the populations they serve and give opportunities for trained CHW to engage actively in community health. Lessons can be learned from different characteristics of these programs and can be applied when implementing or scaling up CHW initiatives in our region.

In the different US states and communities, CHW can offer services and insight that can span the scope of any health care model. In a national study on the Community Health Worker workforce, Health Resources and Services Administration defined the key areas of CHW activities. These include creating more effective linkages between communities and the health care system, providing health education and information, being effective in delivering basic health messages in a culturally appropriate way, assisting, and advocating for underserved individuals to receive appropriate services, providing informal counseling, directly addressing

basic needs, and building community capacity in addressing health issues. In a healthcare system with rising costs, as in the US, another compelling quality of CHW programs is their cost-effectiveness.

In the US, many states (n= 28) recognize Community Health Workers. There is a National Association of Community Health Workers and several certification programs are in existence. Many blueprints for funding Community Health Workers have been developed and implemented.

Community Health Workers in North Dakota can provide all or part of the above-mentioned services to tribal nations and people living in rural areas in the state. North Dakota is home to five federally recognized Tribes. CHW can greatly help health programs through health education, sharing in the maternal-child health programs, prevention, and management of chronic diseases (Diabetes, hypertension and cancers) and can provide significant home-based preventative screenings.

I inspire the committee to vote to pass on HCR 3015 so that we may explore the opportunity for improving health outcomes in North Dakota through the utilization of Community Health Workers.

That concludes my testimony.

Nada Soliman