Mhealth Standards for LMICs sub-group

**Subject:** Mhealth Standards for Emerging Markets  
**When:** Friday, November 20, 2019 11:00 AM-12:00 PM (GMT-05:00) Eastern Time (US & Canada).  
**Where:** MeetingPlace: 1-888-899-9850 ID: 593858#

*See the wiki for a hyperlink to the screensharing program:*

[*http://wiki.hl7.org/index.php?title=Mobile\_Health*](http://wiki.hl7.org/index.php?title=Mobile_Health)

<https://meetingplaceexthq1.verizonwireless.com/a/2570d2ae83d1139edfa2cbb955b91034>

*This sub-group will meet every Tuesday at 11:00 am Eastern U.S. until December 2012, then bi-weekly afterwards*

**Attending:**

* Jon Payne (mHealth Alliance); [paynejd@gmail.com](mailto:paynejd@gmail.com)
* Nadine Manjaro (MHWG co-chair); [Nadine.Manjaro@VerizonWireless.com](mailto:Nadine.Manjaro@VerizonWireless.com)
* John Ritter (EHR and PHR WG co-chair); [johnritter1@verizon.net](mailto:johnritter1@verizon.net)
* Gora Datta (MHWG co-chair); [gora@cal2cal.com](mailto:gora@cal2cal.com)

**Regrets:**

* (None)

**Materials:**

* “MHWG LMIC minutes 20121019.docx “
* “MHWG LMIC Scope and Uses 20121114.docx”

**Minutes:**

1. Use case
   1. The “MHWG LMIC Scope and Uses 20121114.docx” currently focuses on data exchange.
2. Use Case development
   1. LMIC mHealth Use Cases could be conceptualized programmatically as (for example):
      1. Pregnancy care
      2. Child delivery
      3. Early Child Care
         1. Nutrition
         2. Immunization
         3. Education
         4. Sanitation
      4. Vital Records (Birth, Death, Fetal Death)
   2. Use Cases could be formatted conceptually in terms of (for example):
      1. Care Coordination (see Appendix 1)
      2. Care Delivery (aided by mHealth devices and healthcare workers)
      3. Decision Support
         1. Administrative Decision Support (e.g., scheduling a next-visit)
         2. Clinical Decision Support (e.g., medication (or medical equipment or health education/training) delivery
         3. Referrals (care coordination)
         4. Consent and authorizations (from the patient or surrogate) that provide the basis for subsequent health care
         5. Data-aggregation / data-queries
      4. Registry updates (e.g., Vital Records – birth/death)
      5. Population Health Surveillance and Population-Health-Alert-delivery
   3. Our Use Cases should envision distinctions between the use of the “Internet Cloud” and other modes of data exchange and governance.
   4. Use Cases should depict the proposed relationships between the mobile health workers and governing health authorities. For example, the government must be informed of the proposed use of electronic public health systems; delivery of medicines, foods, immunizations, health education; health surveillance; and coordination of care with other entities.
3. Can duplication of LMIC-related efforts be reduced?
   1. Existing mobile health efforts:
      1. LMIC-focused Governments and Ministries of Health
      2. Public/Private Donors (e.g., PEPFAR, USAID, NORAD (Norwegian Agency for Development Cooperation), Gates, Rockefeller, IDRC (International Development Research Center))
      3. Implementers (e.g., Pathfinder, World Vision, Save the Children, Catholic Relief Services)
      4. SDOs and quasi-SDOs (e.g., HL7 MHWG, HL7 IMC, ISO TC215, IHE)
      5. Professional Organizations (e.g., WHO, PHDSC, HIMSS, mHealth Alliance)
      6. Infrastructure vendors (e.g., telecommunications)
      7. Device vendors (e.g., device manufacturers)
      8. Solution providers (e.g., )
      9. Conferences (e.g., mHealth Conference)
      10. Work Groups (e.g., Public Health Task Force, Joint Interoperability Council)
      11. Educational (e.g., academic, vendors)
      12. Research (e.g., CDC, NIH)
   2. Should one of these groups assume a “governance role” or “coordinating role”?? Perhaps, perhaps not…. Governance and coordination is currently occurring informally (because many individuals cross-attend each of these organizations).
4. Next meeting:

* 2012-11-27 at 11:00 AM Eastern U.S.

1. Adjournment

* The meeting adjourned at 12:00 PM Eastern U.S.

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**Appendix 1**

**Common Scenario for mHealth devices vis-à-vis Pregnancy**

**From:** Jonathan Payne [mailto:paynejd@gmail.com]   
**Sent:** Tuesday, November 20, 2012 11:03 AM  
**To:** Manjaro, Nadine  
**Cc:** gora@cal2cal.com; bfleao@gmail.com; tim.a.mckay@kp.org; mshafarm@gmail.com; nathan.botts@gmail.com; johnritter1@verizon.net; Van Duyne, Ron (CDC/OID/NCIRD); Nathan Botts  
**Subject:** Re: Mobile Health for LMIC

Hi all,

I summarized a common mhealth project (community-based antenatal care) that we refer to during our discussion today:

**Scenario:** Coordinate care between clinic midwife, mobile midwife, and community health worker (CHW).

CHW identifies and registers pregnancies in the community. Standard care plan consists of iron tablets during entire pregnancy (dispensed by midwife or CHW) and 4 antenatal visits by a midwife.

Recommended delivery location is at a clinic with a midwife, although mobile midwives or trained birth attendants (TBAs) may also assist a birth in the community. CHW will visit mother 4+ times during pregnancy to provide counseling and to assist mother in maintaining her care plan. The CHW may also record pregnancy history and identify potential risk factors. Urgent risk factors (esp. in the 3rd trimester) may be cause for urgent referral, in which case the CHW may help arrange transportation through an ambulance or local car owners. Prior consent for emergency transport from families can be recorded on phones to expedite the transition of care. Midwives will follow up during antenatal visits on risk factors identified by the CHW (or by a mobile midwife, if additional examination facilities are required). CHWs may also be prompted to follow up on potential issues identified by a midwife. CHWs play an important role in educating mothers on care options, birth preparedness, and family planning counseling. These services may be facilitated by job aids, which can be embedded on a mobile device.

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