

H4+

Strengthening the capacity of community health workers to deliver care for sexual, reproductive, maternal, newborn, child and adolescent health

Technical brief by the H4+ (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank)



World Health Organization



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Background

In countries where Millennium Development Goals (MDGs) 4, 5 and 6 are most lagging, there is a need to accelerate progress to improve the health of women and children and address the unmet needs for sexual and reproductive health and maternal, newborn, child, and adolescent health (SR/MNCAH) of the larger community. This requires investment in and strengthening of national health systems, especially in underserved and hard-to-reach areas. The crisis in human resources for health is one of the most critical factors underlying the poor performance of health systems in resource-constrained settings. This crisis hinders the equitable delivery of effective and quality interventions for SR/MNCAH and other priority health issues—an estimated 4.3 million health workers are needed to fill the gap in 57 countries in Africa and Asia (1).

Government institutions, United Nations agencies, and global partners have been repositioning the role that community health workers (CHWs) can play in increasing access to essential quality health services in the context of national primary health care and universal health coverage. A CHW is defined by WHO as any health worker who performs functions related to health-care delivery; was trained in some way in the context of the intervention; but has received no formal professional or paraprofessional or tertiary education, should be members of the communities where they work, be selected by the communities, be answerable to the communities for their activities and should be supported by the health system (2). The broad application and divergence of this definition at country level as to who is a CHW and what tasks they undertake are noted.^a

Numerous CHW programmes have failed in the past because of unrealistic expectations, poor planning, lack of supportive supervision, and underestimation of resources required to make these programmes work (3). Other CHW

programmes have been designed to address very narrow and specific needs, without taking into account the potential of CHWs in SR/MNCAH. In conjunction with the work of other health cadres, in particular midwives working close to the communities, and when selected, trained, supported, remunerated, motivated, supervised, and deployed within the context of an appropriately financed and organized primary health care system, CHWs can contribute to improving the coverage of essential SR/MNCAH interventions, especially at the primary health care level and in underserved and hard-to-reach areas (4). CHWs can be providers of SR/MNCAH-related health promotion and preventive care and increasingly of curative care thanks to new rapid diagnostic tests, simplified treatment protocols, and mobile health technologies and support systems (3,5). In response to the growing body of evidence on the potential role and effectiveness of CHWs, WHO and partners have published global recommendations on task-sharing / task-shifting as well as evidence-based interventions that CHWs can undertake in the different areas of SR/MNCAH (6-14).

Given the growing momentum and interest in training CHWs in MDG-related health interventions, an expert consultation on this theme was organized by the United Nations health agencies (H4+) in February 2013. The consultation concluded that there was a wealth of training resource packages for CHWs on SR/MNCAH produced by the H4+ and partners. It however highlighted the critical need for strategic partnership among key stakeholders to mount a synergistic response to address gaps identified during the consultations and ensure that countries can adopt a coordinated, evidence-based and effective approach to developing the capacity of CHWs in SR/MNCAH (15). In addition, the group of experts acknowledged the lack of high-standard guidelines to support the supervision and quality assurance of CHW activities in general, as well as the integration of CHWs into community health structures and the wider health system.

^a

The term "community health worker" is often used to refer to very different typologies of volunteer or salaried, professional or lay health workers whose level of training, competencies, scope of practice and integration in health systems vary widely. This inadvertently creates difficulties in reviewing the evidence of their respective contributions to health outcomes. To inform evidence-based decision-making WHO's Health Workforce Department intends to prepare new guidelines on the role, scope and contributions of Community-Based Practitioners, with due attention to the differing occupational classifications and typologies, including lay workers, community health workers, auxiliary/associate professionals, advanced practitioners and professionals - all of whom contribute to community care.



Objective

The objective of this technical brief is to orient country programme managers and global partners as to key elements for strengthening the capacity of CHWs, including health system and programmatic considerations, core competencies, and evidence-informed interventions for CHWs along the SR/MNCAH continuum of care. These key elements need to be adapted and contextualized by countries to reflect the structure, gaps, and opportunities of the national primary health care system, the interaction between the health sector with other sectors, and the specific roles and competencies that CHWs already have within that system. These key elements should also guide H4+ members and partners to take a joint and harmonized approach to supporting countries in their capacity-development efforts. This technical brief is based on recent WHO guidance related to CHWs (6-14) and reflections from the February 2013 expert consultation (15).



Health system and programmatic considerations

CHW programmes can succeed if they are based on appropriate planning and management; this includes having realistic terms of reference and expectations, short and mid-term planning, regular supportive supervision, effective logistic support, linkage to the health system for referral when needed, and reliable estimation of resources required to make them work. Decision-makers should first assess the health service gaps that can be addressed by CHWs, and the feasibility, costs and sustainability of these services. CHW programmes must be part of wider health system and primary health care strengthening efforts to accelerate progress on the health MDGs and not seen as stand-alone programmes.

If CHW programmes are identified to be a viable contribution to the health system, then the following health system and programmatic considerations should guide policy-makers and programme managers in establishing programmes and conducting trainings for CHWs in SR/MNCAH:

- Involve the community and CHWs in the planning and implementation process;
- Determine an appropriate and realistic scope of work that addresses the priority health service gaps;
- Adapt training contents to local needs, using appropriate training methodologies for adult learning, and evaluate and improve the materials;
- Recruit CHWs according to appropriate selection criteria, such as level of literacy, gender, and local residence;
- Ensure a sustainable continuum of capacity development for CHWs through initial training followed by additional training, refresher courses, and regular supportive supervision;
- Align CHW role with the perspectives of the community, and the role of other CHWs and health cadres to optimize an integrated healthcare team approach at the front line of the health system, and ensure intersectoral coordination and synergy with the wider health system;
- Develop the competencies of midwives, nurses, and other health professionals involved in the integrated frontline healthcare team to supervise, support, and collaborate with CHWs;
- Secure equipment, supplies, and job aids necessary to deliver the interventions;
- Motivate CHWs using non-financial and financial incentives;
- Establish effective linkages with and referral/counter-referral to/from other health services;
- Establish an appropriate set of indicators to monitor and track performance of individual CHWs and the programme in general;
- Define performance indicators and conduct periodic programme performance evaluation and quality improvement processes to ensure quality standards in CHW training and programme implementation.



Core competencies to support the delivery of SR/MNCAH care by CHWs^b

Competency is defined as a set of sufficient knowledge, psychomotor, communication, interpersonal relation and decision-making skills and attitudes that enable the performance of actions and specific tasks to a defined level of proficiency (16). In addition to the competencies required to perform specific SR/MNCAH interventions, CHWs should also acquire general core competencies that are critical for them to carry out their functions effectively and with quality. These core competencies span over three different but complementary domains and should be adapted by countries to reflect the scope of work identified for CHW:

Domain 1: working with the community on health promotion, education and counselling

- Identify, support, motivate and mobilize community leaders, social networks, such as mothers' and youth groups, community members and populations at risk (marginalized and vulnerable groups);
- Recognize health concerns in the community and facilitate community learning about health-promoting and preventive care by using different frameworks for behaviour change and a variety of techniques (discussion, demonstration, presentation);
- Use basic counselling techniques, including establishing rapport, active listening, demonstrating empathy, questioning and probing, summarizing and reflecting.

Domain 2: attitudes for promoting and providing quality SR/MNCAH care

- Act consistently in accordance with personal and CHW ethics and standards; treat each individual in a non-judgemental, non-discriminatory, and gender-sensitive manner; ensure confidentiality with full respect for her/his human rights, including the rights of adolescents and young people, marginalized and vulnerable populations;
- Demonstrate empathy, reassurance, non-authoritative communication and active listening, and show respect of knowledge and learning styles of individuals, families and communities, paying attention to ensuring confidentiality, privacy, and respecting individuals' choices as well as their right to consent or refuse care;
- Develop and promote effective relationships with team members and colleagues, including knowledge of their scope of practice which is needed for effective referral, and seek opportunities for continuous learning and professional growth.

Domain 3: effective management to allow the efficient promotion and provision of quality SR/MNCAH care

- Plan regular community and household visits and foster coordination and continuity of care through appropriate and safe referrals and counter-referrals;
- Ensure accurate and complete record-keeping and timely reporting, and use information to make changes and enhance the quality of CHW services;
- Manage effectively logistics of supplies/equipment;
- Demonstrate accountability and transparency in all actions.

^b Note that WHO has developed a series of recommendations as part of the process of releasing guidelines on health professional education. These guidelines include recommendations on curriculum development and core competencies for health professionals and are soon to be available. WHO plans to extend these guidelines to cover both mid-level providers and CHWs.

Key SR/MNCAH interventions

SR/MNCAH interventions that CHWs can perform must be based on the best available evidence and follow a continuum of care, which is a main principle underlying SR/MNCAH programmes. Continuum of care has two meanings – a continuum in the lifecycle from adolescence and before pregnancy, pregnancy, birth and during the newborn period (Figure 1), and a continuum of care from the home and community, where CHWs operate, to the health centre and hospital and back again (2). To this effect, WHO and partners issued several publications of relevance (6-14) that have informed the list of SR/MNCAH interventions in the Annex.

As CHWs come with diverse education levels and backgrounds, and in order to avoid past mistakes of overburdening them with too many tasks, this document has categorized interventions into core and additional according to their level of training requirements.

Core interventions include activities mainly related to community engagement, health promotion, counselling, education and support, identification of individuals who need referral, and data collection.

Additional interventions build on the foundation provided by the core interventions and include in general activities that require higher-skill training, such as providing curative care, running rapid tests and managing results, or distributing medicines and supplies. They should be implemented with closer monitoring and supervision, and, as needed, within the context of operational research, to ensure that they are feasible, safe and effective for each setting^c.

As a general approach, countries should ensure that the core interventions are first implemented effectively by CHWs before rolling out the additional interventions. However, it is critical that countries adapt the proposed categorization of core and additional to local needs and context, such as disease burden, access to services, national policy, how the CHW role is defined, as well as wider programmatic and feasibility considerations. The range of CHWs tasks should be established in such a way as to avoid overloading them and allow seamless integration of their different activities.

Figure 1

The lifecycle continuum of care

Maternal health

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