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

UNFPA

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WHO/FWC/MCA/15.04

Acknowledgements

This technical brief was developed by the World Health Organization Department of Maternal, Newborn, Child and Adolescent Health and the Department of Health Workforce and by the United Nations Population Fund, with input from other WHO Departments and the other H4+ agencies, including UNAIDS, UNICEF, UN Women, and the World Bank. Special thanks to Nguyen-Toan Tran, consultant, who led the drafting of this document. This report was funded by a grant from the Department of Foreign Affairs, Trade and Development Canada.

Graphic design: Valentina Compagnoni

Printed by the WHO Document Production Services, Geneva, Switzerland

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 cassifications 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.

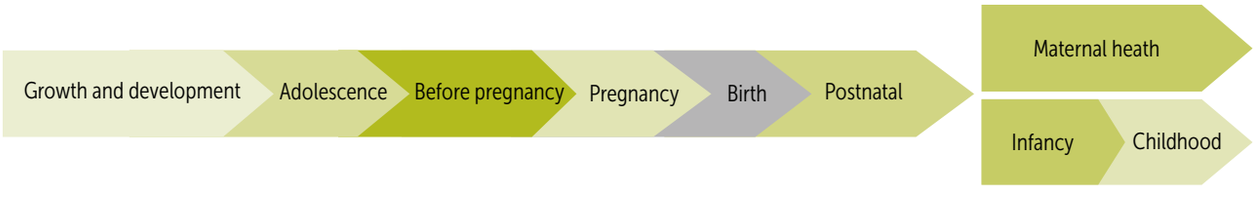
Core interventions include activities mainly related to community engagement, health promotion, counselling, education and support, identification of individuals who need referral, and data collection.

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



[c] There are also feasibility and ethical issues related to CHWs delivering some of the more specialized interventions related to adolescent SRH and gender-based violence, for which further research is needed.

Actions for countries

- Assess the health service gaps that CHW programmes can address, including feasibility, costs and sustainability of these services, and the potential role of CHWs in increasing access to SR/MNCAH, including malaria, tuberculosis and STI/HIV and nutrition. CHW programmes must be a coherent part of wider health system and primary health care strengthening efforts.
- Analyse the current national policies and practices related to CHW status, selection, training, supervision, remuneration and effective linkage to the health system. The health system and programmatic considerations outlined in this document can guide the capacity development of CHWs.
- Given the broad role that CHWs can play in primary care, CHW programme managers should define interventions and competencies related to the health MDGs (and future health-related Sustainable Development Goals), including SR/MNCAH that are most relevant to that setting. Curricula should be based on the best available evidence and cover promotive, preventive, and curative aspects of care related to general health-enabling interventions and to SR/MNCAH, yet adapted to local specificities.
- Prepare and engage communities from the outset in the participatory selection processes of CHWs and in the assessment of community needs.
- Establish an appropriate set of indicators to monitor and track the performance of individual CHWs and programmes in general, provide regular supportive supervision to CHWs, and conduct ongoing monitoring and evaluation of CHW programmes.
- To ensure integration, synergy, and sustainability, the country action plan to develop and strengthen the capacities of CHWs in SR/MNCAH should be designed, implemented and assessed, including identification of required resources, by relevant stakeholders under the leadership of the Ministry of Health.

The H4+ and partners will support these actions by:

- Advocating, assisting and investing resources to help countries consider the most appropriate and feasible CHW model for increasing access to SR/MNCAH, and adaptation to local health system contexts;
- Working with governments and non-government organizations to effectively develop the capacity of CHWs in SR/MNCAH, strengthen the capacity of other cadres involved in the integrated frontline healthcare team to provide supportive supervision to CHWs, scale up CHW programmes according to best practices, and monitor and evaluate programmes;
- Conducting further research to fill the knowledge gaps on areas such as cost-effectiveness of CHW programmes; feasibility, acceptability and safety of CHWs in relation to GBV and adolescent health interventions; role of CHWs in maternal death surveillance and response; use of mobile technologies in CHW interventions; most equitable and cost-effective ways to reach populations living in remote areas; or optimal number and distribution of CHWs in different populations, including in hard-to-reach settings.
- Supporting the update of existing training resource packages on SR/MNCAH, and the development of new ones where not yet available;
- Helping with communication efforts aimed at promoting the role of CHWs in SR/MNCAH.

Annex: List of SR/MNCAH interventions

WHO and partners issued several publications of relevance that have informed this list of SR/MNCAH interventions (6-14). 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.

As a general approach, countries should ensure that the core interventions are first implemented effectively by CHWs before rolling out the additional interventions. It is critical that countries adapt the proposed categorization of core and additional according 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 CHWs and allow seamless integration of their different activities.

Interventions

Interventions	Core/ Additional	Sources
1. Sexual heath, family planning, and pre-pregnancy		
• Educate women, men, families, and community to:		
• Be aware of the benefits of safe sex, family planning and birth spacing starting from the pre-pregnancy period, during pregnancy, and after childbirth.	core	6
• Enable adolescents, women, men to access to various reproductive health services through integrated and linked services.	core	6
• Be aware of signs of domestic and sexual violence. • In case a woman discloses violence, provide basic support (it is critical to ensure a private setting, confidentiality, and to not disclose this information to anyone else), by listening carefully and empathetically (but not pressuring her to talk), being non-judgmental and supportive, and helping her access information about resources and services if these are available.	additional	6, 9
• Counsel on contraceptive methods including emergency contraception.	core	6
• Refer for family planning methods not available at community level, such as longer-acting methods (injectables, implants, IUDs), and permanent methods (male and female sterilization).	core	7
• Distribute condoms and pills, including emergency contraception.	core	7
• Initiate and maintain use of injectable contraceptives using a standard syringe (to be considered with targeted monitoring and evaluation).	additional	8
• Detect pregnancy using pregnancy test and counsel on contraceptive or pregnancy options.	additional	13
• Prevent and manage STIs, including support for Mother-to-Child Transmission of HIV and Syphilis.	additional	7
• Distribute folic acid supplement to prevent neural tube defects.	additional	7
2. Safe abortion care		
• Educate women, men, families, and community to:		
• Be aware of SRH, including safe sex, family planning, unwanted pregnancy, coerced sex, legal grounds for safe abortion.	core	6
• Be aware of the consequences of unsafe abortion.	core	6
• Be aware of the availability of family planning services at community level (e.g. condoms, pills, injectables, emergency contraception) and referral level (e.g. implants, IUDs, male and female sterilization).	core	6
• Be aware of the availability of pregnancy detection and safe abortion services.	core	6
• Identify needs for safe abortion care and facilitate prompt referral to pregnancy detection and safe and legal abortion services.	core	13
• Identify women with signs of complications of unsafe abortion, provide first aid and refer promptly.	additional	6
• Distribute condoms and pills, including emergency contraception.	additional	6

	Core/ Additional	Sources
2. Safe abortion care - continued		
• Be aware of signs of domestic and sexual violence and refer as appropriate. • In case a woman discloses violence, provide basic support (it is critical to ensure a private setting, confidentiality, and to not disclose this information to anyone else), by listening carefully and empathetically (but not pressuring her to talk), being non-judgmental and supportive, and helping her access information about resources and services if these are available.	additional	6, 9
3. Pregnancy care		
• Promote and support:		
• Appropriate care-seeking behaviour and antenatal care during pregnancy, including the recommended minimum of four antenatal care visits.	core	8
• Self-care at home, healthy lifestyle including harmful effect of smoking and alcohol use.	core	6
• Companionship during labour.	core	8
• Sleeping under insecticide-treated nets during pregnancy.	core	8
• Birth and complication preparedness, including educate on signs of labour and on danger signs.	core	6, 8
• Skilled care for childbirth.	core	8
• Adequate nutrition and iron and folate supplements during pregnancy.	core	8
• Safe sex and birth spacing.	core	8
• Educate women and families about dangers signs and need for urgent referral to hospital.	core	6
• Promote and support PMTCT and interventions to prevent and manage HIV and TB:		
• PMTCT: discuss plans for childbirth, discuss ARVs (when to start, where to keep it), introduce information regarding infant feeding options.	core	11
• TB screening and testing during pregnancy as well as support for adherence throughout the necessary diagnostic processes and adherence to treatment or TB preventive therapy, as necessary.	core	11
• Promote exclusive breastfeeding in the first 6 months.	core	8
• HIV testing and TB screening (regardless of HIV status) during pregnancy, as well as support for adherence throughout the necessary diagnostic processes and adherence to treatment or TB preventive therapy, as necessary.	core	6, 10, 14
• Distribute the following oral supplements to pregnant women (to be considered with targeted monitoring and evaluation):		
• Calcium supplementation for women living in areas with known low levels of calcium intake.	core	8
• Routine iron and folic acid supplementation.	core	8
• Intermittent presumptive therapy for malaria for women living in endemic areas.	core	8

	Core/ Additional	Sources
3. Pregnancy care - continued		
• Vitamin A supplementation for women living in areas where severe vitamin A deficiency is a serious public health problem.	core	8
• Promote and support interventions for smoking cessation during pregnancy for improving birth outcomes.	additional	6, 7
• Be aware of signs of domestic and sexual violence and refer as appropriate. • In case a woman discloses violence, provide basic support (it is critical to ensure a private setting, confidentiality, and to not disclose this information to anyone else), by listening carefully and empathetically (but not pressuring her to talk), being non-judgmental and supportive, and helping her access information about resources and services if these are available.	additional	6, 9
4. Childbirth care		
• Promote and support skilled cared for birth/facility-based childbirth.	core	6, 8
• Support for transport to and from health facility.	core	6
• Provide continuous support for the woman during labour, in the presence of a skilled birth attendant.	core	8
• Administer misoprostol to prevent PPH, only where a well-functioning lay health worker programme already exists, skilled birth attendants are not present and oxytocin is not available.	additional	8
5. Postpartum care		
• Promote postpartum care.	core	6
• Provide information and counselling on self care at home, nutrition, safer sex, breastfeeding, birth spacing and family planning, healthy lifestyle including harmful effects of smoking and alcohol use, malaria prevention and management of malaria, sleeping under insecticide-treated nets.	core	6
• Recognize dangers signs and refer urgently to hospital.	core	6
• Support women living with HIV including ART and TB screening, prevention, and care regardless of HIV status.	core	6
• Report birth and death (vital registration).	core	6
• Be aware of signs of domestic and sexual violence and refer as appropriate. • In case a woman discloses violence, provide basic support (it is critical to ensure a private setting, confidentiality, and to not disclose this information to anyone else), by listening carefully and empathetically (but not pressuring her to talk), being non-judgmental and supportive, and helping her access information about resources and services if these are available.	additional	6, 9

	Core/ Additional	Sources
6. Newborn care		
• Promote and support basic newborn care and care of low-birth weight infants:		
• Support for routine care and follow up visits (3 home visits after birth at day 1, 3 and 7; extra visit for small babies at day 1, 2, 3, 4, 14; visit referred babies on the day they returned home).	core	12
• Thermal protection for all newborns to prevent hypothermia.	core	6, 7
• Early initiation and exclusive breastfeeding (within the first hour).	core	6, 7
• Infection prevention: general hygiene; frequent hand washing particularly after going to the toilet, handling baby's stools, and coming home from outside; hygienic cord and skin care; safe disposal of baby's faeces.	core	6
• Care of a small baby without breathing and feeding problems: frequent breastfeeding, skin-to-skin contact.	core	6
• Newborn stimulation and play.	core	6
• Support for continued Kangaroo Mother Care in the home for low birth weight infants, after initiation at the health facility.	core	7, 8
• Birth registration.	core	6
• Promotion and provision of insecticide-treated bed nets	core	6, 7
• Recognize danger signs and refer urgently to hospital.	core	6
• Promote routine immunization according to national guidelines.	core	8
• Provide routine immunization according to national guidelines.	additional	7
• Promote and support timely ARV prophylaxis in HIV-exposed newborns.	additional	6
• Promote and support proper feeding practices in HIV-exposed newborns according to national policies	additional	11
7. Infancy and childhood care		
• Promote and support:		
• Exclusive breastfeeding for the first 6 months of life.	core	6, 7, 8
• Appropriate complementary feeding.	core	6, 7
• Child stimulation, appropriate play, and communication activities.	core	6
• Hand washing.	core	6
• Sanitation and appropriate disposal of faeces.	core	6
• Recognition of signs of illness and timely care-seeking.	core	6
• Referral of children under 12 months and in contact with a TB case to the clinic for further assessment, regardless of HIV status. Systematic screening of children 12 months and above for TB signs in households affected by TB, and referral of symptomatic children for further assessment.	core	14

	Core/ Additional	Sources
7. Infancy and childhood care - continued		
• Home care during illness (adherence to treatment, increase fluid intake and continue feeding, sleep under insecticide-treated bed net, refer urgently to health facility if sicker or no improvement).	core	6
• Provide and promote insecticide-treated bed nets.	core	6
• Identify and urgently refer children with signs of severe illness.	core	6
• Provide vitamin A supplementation from 6 months of age in Vitamin A deficient populations.	core	7
• Screen children living with HIV at each visit for poor weight gain, fever and current cough to rule out active TB. If they have one of these symptoms, they should be accompanied to the clinic to be evaluated for TB and other diseases.	core	11
• Promote routine immunization according to national guidelines.	core	8
• Provide routine immunization plus H. influenzae, meningococcal, pneumococcal, and rotavirus vaccines.	additional	7
• Identify and manage severe acute malnutrition without complications.	additional	7
• Identify and manage diarrhoea, pneumonia, tuberculosis and malaria.	additional	6
• Assist in the provision of isoniazid preventive therapy for six months to children living with HIV who are more than 12 months of age and who do not have the above symptoms and no contact with a TB case.	additional	10
8. HIV and TB interventions (complementing the HIV/TB interventions described above)		
• Sensitize and educate women, men, families, and communities on HIV and TB, including:		
• Key information on HIV, STIs, TB, safer sex and condom use, including distribution of condoms and educational materials.	core	11
• HIV prevention, counselling and testing.	core	10
• Recognition of TB symptoms and TB prevention counselling.	core	11
• Adherence education and counselling on ART, TB treatment, and isoniazid preventive therapy.	core	11
• Promote and support early follow-up (up to 3 months from starting ART), and long-term follow up (3 months after initiation of ART).	core	11
• Advise on prevention for people who inject drugs as part of the comprehensive package of harm reduction.	core	11
• Inform on circumcision, including on pre-surgical counselling.	core	11
• Promote and support positive prevention, including education on sexual and non-sexual transmission of HIV, reproductive choices and family planning, prevention of other infections, physical activity, nutrition, clean water, and other hygiene measures.	core	11
• Recognize side-effects of TB and/or HIV medications and encourage assist consultation or clinic visit when necessary.	core	11

	Core/ Additional	Sources
8. HIV and TB interventions (complementing the HIV/TB interventions described above) - continued		
• Screen all adults and adolescents living with HIV at each visit for current cough, fever, weight loss or night sweats to rule out active TB:		
• If they do have one of the symptoms, then encourage/assist visit to clinic for evaluation for TB and other diseases.	core	11
• If they have none of the symptoms, then active TB can be reasonably ruled out and at least six months of isoniazid preventive therapy (IPT) should be initiated, regardless of pregnancy or if they are on ART.	additional	10
• Provide ART, combined TB treatment, cotrimoxazole preventive therapy, and ART directly observed treatment (DOT) between regular clinical visits.	additional	11
• Conduct testing and counselling, including pre-test counselling, conduct and interpret the test, and post-test counselling:	additional	11
• Offer HIV testing and counselling, including to couples, pregnant women, and TB patients and people with presumptive TB.	additional	11
• Screen for TB and refer for further testing if needed.	additional	11
• For facility-based clinical management of HIV in neonates, children, pregnant women and adult by CHWs, see relevant WHO guidelines.	additional	11

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