CHWs in Humanitarian Settings:

Scoping review

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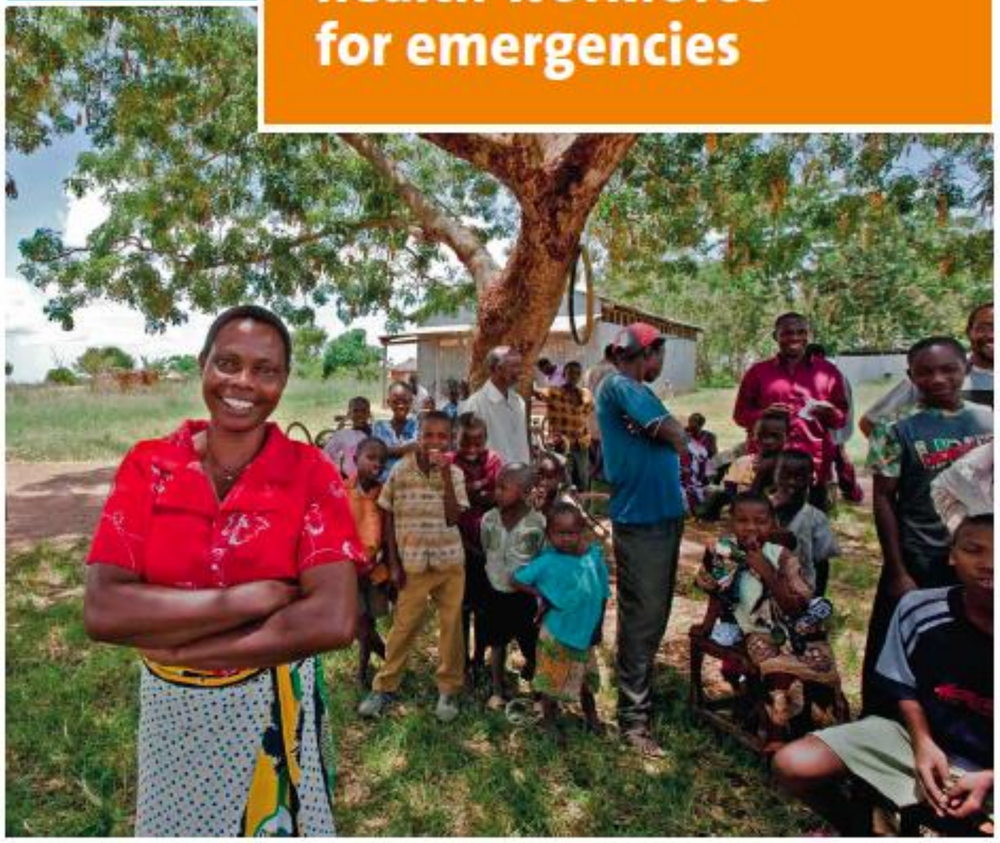
unicef

Joint statement

Scaling up the community-based health workforce for emergencies



global health workforce alliance

UNHCR

unicef

World Health Organization

International Federation of Red Cross and Red Crescent Societies

Community health workers - the first response in emergencies

January 2010

In times of crisis, what often makes headlines is the international response. But in most cases, those who provide the initial lifesaving care are health workers from the very communities affected.

UNICEF/Cornelia Walther

WHO works with governments and partners to equip, train and prepare community health workers worldwide to provide critical care for millions of people affected by natural disasters, war and other crises, and the health risks that follow.

Local health workers help ensure equity in health at grassroots levels - urban and remote - and contribute to country efforts to ensure health care for all, particularly the poor, underserved and underprivileged. These workers are trained in hygiene, first aid, immunization and other essential primary health care services and form the backbone of any emergency health response.

This photo essay highlights the critical role these workers play in saving lives by preparing for and responding to emergencies.

Read the photo story

Related links

Health Action in Crises

WHO Programme on Disease Control in Humanitarian Emergencies

Community health workers

Features

Features homepage
All features by year, topic and WHO region

Online Q&A
Answers to topical questions

Fact files
10 facts and photos on health topics

HEALTH AFFAIRS BLOG

RELATED TOPICS:
COVID-19 | PUBLIC HEALTH | PANDEMICS | ACCESS TO CARE | SYSTEMS OF CARE

To Strengthen The Public Health Response To COVID-19, We Need Community Health Workers

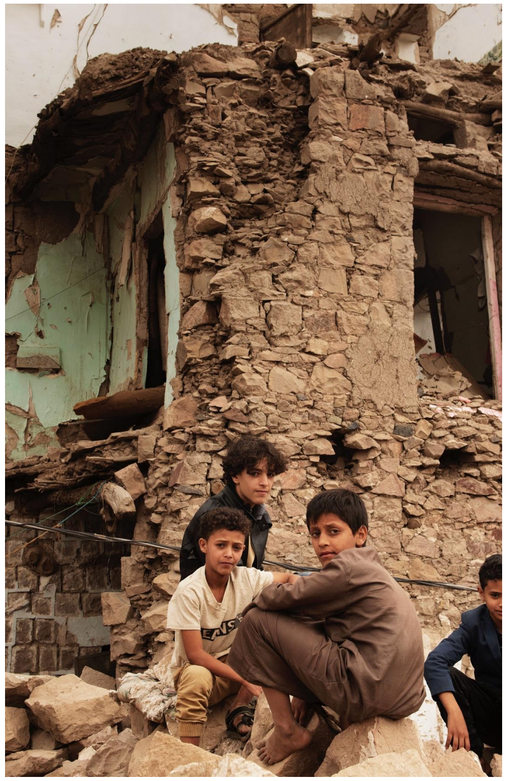
Denise O. Smith, Ashley Wennerstrom

MAY 6, 2020

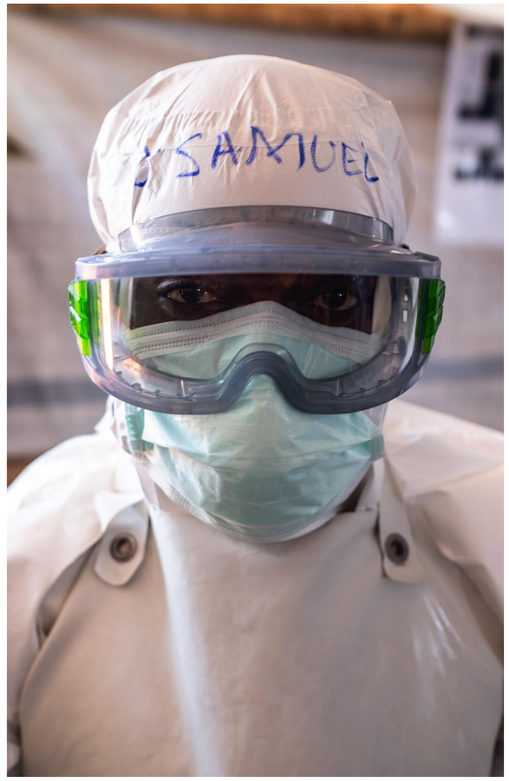
10.1377/hblog20200504.336184

Country Case Studies

South Sudan
(conflict)



Yemen
(conflict)



West Africa
(Ebola)

Bangladesh
(flooding)

Previous webinar on case studies:
https://www.youtube.com/watch?v=bFk_4KPDzsI

METHODS

Objective:

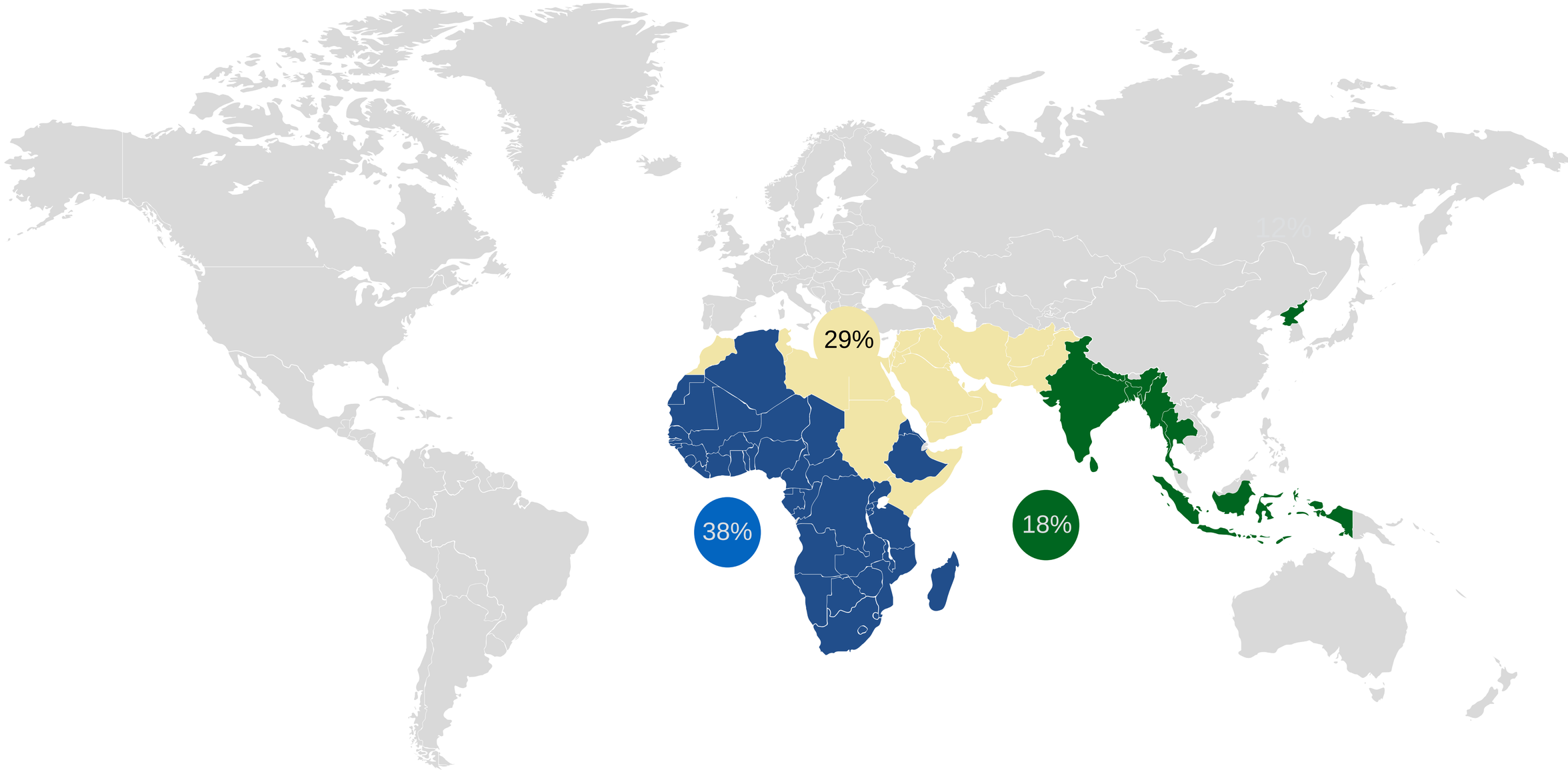
- To map the existing evidence and to document the experiences with health and nutrition service delivery by CHWs in humanitarian settings.

- Search of 9 databases
- Grey literature requested
- Reference screening
- Systematic review of 3,709 documents
- 219 included in review (175 peer-reviewed articles)


RESULTS

LITERATURE CHARACTERISTICS

WHO REGIONS



TYPE OF CRISIS

CONFLICT
65%

DISEASE OUTBREAK
20%

NATURAL DISASTER
11%

NUTRITION EMERGENCY
2%

General population
83%

Refugee/IDP camp
21%

Variation in CHW characteristics:

- 16-55 years of age
- Women or mixed
- No education to secondary education
- Volunteer to range of payments
- Integrated into health system or supported by NGO
- Wide range of services

Lead author	Title	Year	Publishing Organization	Type of document	Journal/ conference	World Health Organization region	Country	Type of crisis	Crisis setting	Thematic areas	Interventions provided by CHWs	CHW cadre	Study methods	Key findings
Adam	Relationship between implementing interpersonal communication and mass education campaigns in emergency settings and use of reproductive healthcare services: evidence from Darfur, Sudan	2015	Tokyo Medical and Dental University	Journal article	BMJ Open	Eastern Mediterranean	Sudan	Conflict	Camp	Reproductive health	Home visits and mass education activities	Maternal community health workers	Pre-post surveys, no comparison	– Health communication and health services not appropriate for displaced persons who may be from different ethnic groups, have different culture. – CHWs used in IDP camp setting to do behavior change interventions for maternal health. – Awareness and use of maternal health services over time. – Significant associations between receiving behavior change interventions and use of maternal health services.
Adam	The influence of maternal health education on the place of delivery in conflict settings of Darfur, Sudan	2015	Tokyo Medical and Dental University, University of Khartoum	Journal article	Conflict and Health	Eastern Mediterranean	Sudan	Conflict	Camp	Maternal health, reproductive health	Health education	Maternal health workers	Household survey	– Female community members were trained to provide maternal health education and to promote facility delivery among IDP women. Receiving a home visit for maternal health education was statistically significant with place of delivery.
Ager	Health service resilience in Yobe state, Nigeria in the context of the Boko Haram insurgency: a systems dynamics analysis using group model building	2015	Columbia University, Queen Margaret University, University of the Western Cape, Partnership for Reviving Routine Immunization in Northern Nigeria and Maternal Newborn Child Health, University of Montreal	Journal article	Conflict and Health	Africa	Nigeria	Conflict	General population	Not specified	Not specified	Community health workers	Qualitative interviews, group model building	– CHWs coordinated with community members to warn health workers when it was not safe to travel to communities.
Ahmadzai	Scaling up TB DOTS in a fragile state: post-conflict Afghanistan	2008	Afghanistan Ministry of Public Health, Management Sciences for Health	Journal article	International Journal of Tuberculosis and Lung Disease	Eastern Mediterranean	Afghanistan	Conflict	General population	Infectious diseases	Diagnosis and treatment of tuberculosis	Community health workers	Analysis of quantitative program data	– CHWs were trained to diagnose and treat TB (with DOTS) in communities. CHWs were see as an important part of the effort that increased the number of districts implementing DOTS by 600% over four years, increased the number of patients treated for TB by 380% over two years, and increased the cure rate from

NEED FOR COMMUNITY-BASED SERVICES

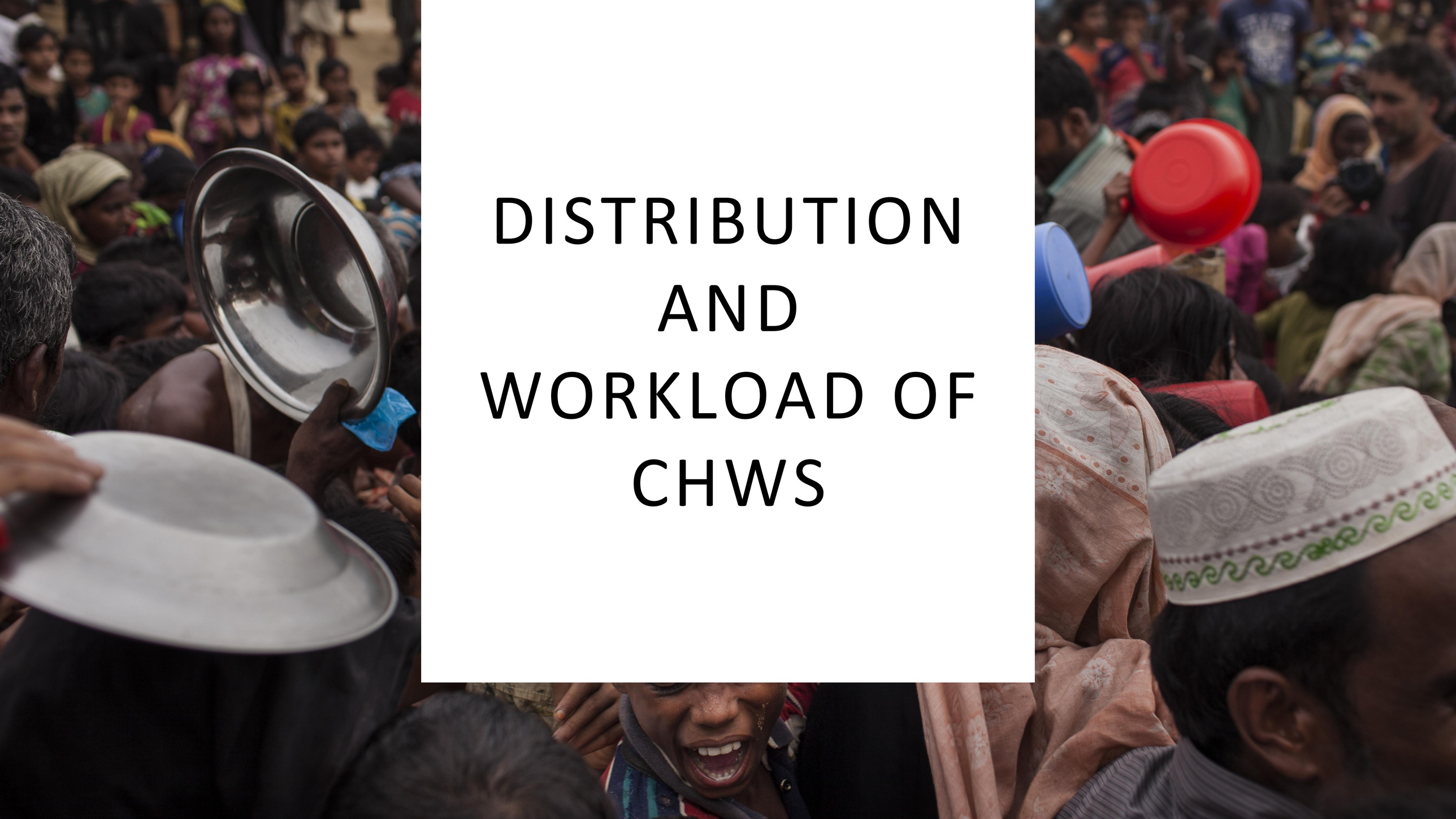
- Health facilities closed, looted, supplies taken, staff gone
- Decreased access
- Neglect of health services by governments
- Community-based services more resilient
- Easier access
- Greater trust

MAINTAINING ESSENTIAL SERVICES

- CHWs mostly continued services, with some declines
- Conflict, outbreak, natural disasters
- Adapted services
- Moved with displaced communities
- Provided services for IDPs and host communities
- Major barriers were unclear policies and supply chain disruptions

POLICY AND FUNDING

- Transitions between development and emergency programming caused slow response
- Short-term project funding led to early closure of programs
- Flexible funding allowed more efficient transitions
- Humanitarian funds used for health system strengthening
- Sustainability improved through integration of services into national health systems



DISTRIBUTION AND WORKLOAD OF CHWS

- CHWs complained of too many tasks and competing work priorities
- Too few CHWs to cover large areas
- Travel expenses not reimbursed
- Villages where CHW was not resident experienced reduced service, especially during conflict

SELECTION OF CHWS

- Importance of community selection of CHWs for trust and acceptance
- Difficulty meeting education/literacy requirements
- Low literacy CHWs provided services in several settings, with challenges
- Need adapted low literacy tools

TRAINING

- Training for emergency response often came too late
- E.g., “No-touch” iCCM training came late in the Ebola outbreak

SUPERVISION & MONITORING

- Reductions in supervision frequency
- Insecurity, lack and cost of transportation, flooding, shortage of supervisors
- Use of local supervisors and peer supervisors
- Use of mobile phones for supervision and data collection

SUPPLY OF COMMODITIES

- Stockouts common
- Drugs consumed in health facilities
- Adverse weather
- Inadequate storage
- Insecurity
- Population movements
- Emergencies exacerbated supply chain weaknesses

Solutions included:

- Parallel supply chains
- Buffer stocks
- Decentralized storage
- Inconspicuous storage
- Runaway bags

COMMUNITY ENGAGEMENT & SERVICE UTILIZATION

- Community selection of CHWs
- Engagement of community leaders and religious leaders
- Community ownership led to community support for CHWs
- Community health committees facilitated CHW programs

- Conflict had negative and positive impacts on utilization of CHWs
- Reduced trust and social mobilization efforts
- Preference for CHWs over facilities
- Difficult travel to facilities
- Fear of facilities during outbreak
- Greater trust in local CHWs
- Engagement of community leaders

REFERRAL TO HEALTH FACILITIES

- Long distances, lack and cost of transportation were primary challenges
- CHWs not equipped with supplies to accompany patients
- Insecurity
- Closed facilities
- Lack of drugs and supplies
- Fear of facilities during outbreak

- In Myanmar, referral of pregnant women was not possible
- CHWs provided community-based emergency obstetric care

MOTIVATION & RETENTION OF CHWS

- Financial compensation was key motivator
- Volunteers had difficulty meeting basic needs
- Desire to help community
- Community appreciation was motivator
- CHWs left position because of lack of payment, overwhelming duties, family opposition, spouse relocation, other opportunities

SECURITY OF CHWS & SUPERVISORS

- Frequent travel on dangerous roads
- Possession of valuable commodities
- Perceived alignment in conflict
- Targeted by armed actors
- Exposure to disease during outbreak
- Challenged ability to recruit, retain, supervise, supply

Potential solutions:

- Security
- Coordination with local communities
- Negotiating safe access
- Pairing male and female CHWs
- CHWs working only in home community
- Supervisors from local area
- Remote supervision via mobile phone
- Security training

MENTAL HEALTH

- CHWs experienced psychological trauma from experience of crisis and work as CHW
- Insecurity/violence/disaster/loss of loved ones
- Work stress
- Lack of support/resources

GENDER

- Female CHWs seen as more appropriate for maternal and child health services
- Literacy/educational requirements
- Gender norms
- Lack of women in supervisor/administration roles
- Security risks
- Women more exposed during outbreaks
- CHW role provided income, knowledge, social status, freedom to travel

EMERGENCY RESPONSE

- CHWs first responders in emergencies
- Conflict, natural disasters, disease outbreaks, nutrition emergencies
- Provided care before any outside support
- CHWs not always engaged in emergency activities
- CHWs more trusted than outside actors
- Local knowledge was key

EMERGENCY PREPAREDNESS

- Emergency preparedness rarely mentioned
- CHWs were inadequately prepared
- Calls for integrating CHWs into preparedness plans and providing training


LESSONS LEARNED

- Need for community-based services
- CHWs can continue providing services in acute and prolonged crises
- Humanitarian response should use CHWs
- CHWs should be included in emergency preparedness plans
- Flexible and longer-term funding will improve emergency response and health system strengthening

- Communities without a resident CHW may experience service gaps
- CHWs should be selected by communities
- It may be necessary to recruit low-literacy CHWs
- Supervisors from local communities facilitated continued supervision
- Mobile phones can be used for remote supervision and data collection

- Plan for supply chain disruptions and population movements
- Engage community leaders and community health committees
- Local solutions to facilitate referrals
- Managing severely ill patients when referral is not possible
- CHWs should receive reasonable remuneration

- CHW programs should be designed to enhance security of CHWs and supervisors
- CHWs and supervisors should be included in preparedness plans and should receive security training
- Mental health of CHWs should be considered in program operations and psychosocial support should be provided

- Consider impacts of hiring practices on gender equity
- Reduce challenges faced by female CHWs
- Institutionalization of CHWs

RESEARCH QUESTIONS

1. How can CHWs be rapidly located, contacted, mobilized, trained, and supplied following an acute crisis?
2. What is the effectiveness of strategies to maintain supervision, supply chain, and monitoring when travel is limited?
3. What is the effectiveness of strategies to maintain supervision, supply chain, and monitoring when travel is limited?
4. What is the quality of care/adherence to protocols delivered by low literacy CHWs?

5. What is the quality of care delivered by CHWs managing severely ill patients when referral is not possible and what are the patient outcomes?
6. What is the effectiveness of strategies to improve security of CHWs and supervisors?
7. What is the cost-effectiveness of emergency response strategies that include CHWs compared to strategies focused on fixed facilities or mobile clinics that do not include CHWs?
8. How can CHWs be most effectively used in prevention and response to disease outbreaks?

Journal of Global Health collection on community health in emergencies: http://www.jogh.org/col-emergencies.htm


THANK YOU

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