UNHCR
The UN Refugee Agency

OPERATIONAL GUIDANCE:

COMMUNITY HEALTH IN REFUGEE SETTINGS

ACKNOWLEDGMENTS

Main authors:

- Stephanie Gee (independent consultant)
- Sandra Harlass (UNHCR Geneva, Switzerland)

Reviewers and other contributors:

IRC
- Aston Benjamin Atwiine
- Elaine Scudder
- Hanan Jabiri
- John Kiogora
- Laura Miller
- Lilian Kiapi

Medical Teams International
- Bryna Betis
- Erica Brim
- Joy Wright
- Sukanya Borthakur
- Trina Helderman

Save the Children
- Janet Mayers
- Nureyan Zunong
- Rachael Cummings

UNHCR
- Allen Gidraf Kahindo Maina
- Ann Burton
- Asis K. Das
- Emmet Kearney
- Erin E. Anastasi
- Francesca Coloni
- Julius Kasozi
- Kazi Nazmus Sakib
- Maria Cecilia Lopez
- Marian Schilperoord
- Meghan Obermeyer
- Peter Ventevogel
- Terry Njeri Theuri
- Vincent Kahi

UNICEF
- Naureen Naqvi

Suggested citation: United Nations High Commissioner for Refugees (2022). Operational Guidance: Community Health in Refugee Settings. Geneva, Switzerland,
Cover photo: © UNHCR/ David Azia
Graphic design: Design@Bay

Table of contents

Abbreviations

ART	Antiretroviral therapy
ASRH	Adolescent sexual and reproductive health
CBS	Community-based surveillance
CBHW	Community-based health workforce
CHW	Community health worker
EWARS	Early warning and response system
GAM	Global acute malnutrition
GBV	Gender-based violence
HIV	Human immunodeficiency virus
iCCM	Integrated community case management
IEC	Information, education and communication
iRHIS	Integrated refugee health information system
IYCF	Infant and young child feeding
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and queer and other diverse identities
MHPSS	Mental health and psychosocial support
MISP	Minimum initial service package
MoH	Ministry of health
MUAC	Mid-upper arm circumference
NCD	Non-communicable disease
NGO	Non-governmental organisation
ORS	Oral rehydration salts
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission
PPE	Personal protective equipment
PSEA	Prevention of sexual exploitation and abuse
RCCE	Risk communication and community engagement
SBCC	Social and behaviour change communication
SDG	Sustainable development goal
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
TB	Tuberculosis
TBA	Traditional birth attendant
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, sanitation and hygiene
WHO	World Health Organisation

Glossary of terms

Community Health Care is defined in this operational guideline as the delivery of promotive, preventive, and basic curative and rehabilitative health services at community level.

Community-based Health Workforce (CBHW) comprises all those based in the community who contribute to better health outcomes by promoting health, creating a healthy environment, and providing primary health care. For the purpose of this document, it does not include formally trained health workers (nurses, doctors, midwifes etc) with whom the CBHW will establish close links.

Community Health Workers (CHW) are defined in the context of this document as "health workers based in communities who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours".[1]

Health Protection, Promotion and Prevention:

Health protection involves reducing threats to the health of the population, including disease-causing agents (e.g., ensuring safe food and water supplies, controlling infectious diseases, surveillance activities).

Health promotion is the process of enabling people to increase control over, and to improve their health. It goes beyond preventing disease to strengthening skills and resiliency and may include a wide range of social and environmental factors that influence health (e.g., health education, peer support groups, community kitchen gardens).

Prevention includes actions that prevent the occurrence of a disease, slow its progress or reduce the health impact of an established disease. This includes:

- Primary prevention – actions that prevent the onset of a disease (e.g., immunisation, use of insecticide treated nets, hygiene practices).
- Secondary prevention – actions that identify the presence of a disease in its earliest stages and steps to reduce the progression of the disease (e.g., screening for high blood pressure, nutrition screening and referrals, early recognition and treatment of childhood illnesses using an integrated community case management approach).
- Tertiary prevention – reducing the impact of an established disease or condition, which may include supportive and rehabilitative interventions (e.g., providing ORS, supporting treatment adherence for people living with HIV, facilitating care for chronic disease patients and older persons).

Social and Behaviour Change Communication (SBCC) is the strategic use of communication approaches to promote changes in knowledge, attitudes, norms, beliefs, and behaviours. It recognises that simply providing information is not effective in changing health behaviours, instead it is necessary to address the determinants of behaviour change at various levels, including individual, family, community and society.

mHealth, or mobile health, refers to the use of mobile wireless technologies (mobile phones, tablets, apps etc) for health services and information.

1. Introduction

1.1 Purpose

These operational guidelines provide practical orientation for UNHCR and partner staff in the field on the provision of community health services for refugees. The document consolidates guidance on effective community health interventions, provides background information and definitions and covers essential components of community health programming in refugee contexts.

1.2 Scope

These guidelines are relevant to all UNHCR operations in low and middle-income countries, including refugee camps, settlements, rural and urban populations, and in all phases of displacement. The guidelines are directed primarily at UNHCR public health personnel and health partner management and technical staff. This guideline is informed by key UNHCR strategies and policies including the Global Compact on Refugees, and UNHCR's Global Strategy for Public Health 2021-2025 as well as global health agendas and approaches including the 2030 Agenda for Sustainable Development and the principles of primary health care (PHC) and universal health coverage.

To be effective, the community-based health workforce (CBHW) must be well integrated with both the formal health system as well as with existing community systems. This includes social networks, government agencies, non-governmental organisations (NGOs), faith-based organisations and civil society organisations that promote health through social and behaviour change communications (SBCC) and community-based health service provision. In addition, staff and trained workers or volunteers from various sectors such as water, sanitation and hygiene (WASH), nutrition, protection, food security, shelter and education are key to supporting healthy living.

While recognising the importance of these groups, this document will focus on community health approaches for the following CBHW cadres:

- Trained community health workers (CHWs) (or equivalent).[2]
- Trained volunteers or workers (e.g., peer educators, support group leaders, other health-related volunteers).
- Informal health providers such as traditional birth attendants (TBAs) and traditional healers who have been mobilised to support primary health services.

The term CBHW will be used throughout the document, where specific actions or activities refer primarily to a specific cadre of the CBHW (e.g., CHWs, peer educators) those are indicated. This operational guideline is intended to inform the development of effective community health programmes and is not meant to provide clinical guidance for health care providers. The recommended interventions listed are not exhaustive, and national health policy and guidelines should be given priority as well as contextual considerations, when determining interventions and approaches.

1.3 Rationale

Critical shortages of skilled health care workers and persistent inequities in health access and outcomes present major barriers to advancing universal health coverage and achieving Sustainable Development Goal (SDG) 3 – to ensure healthy lives and promote well-being at all ages. Community health approaches have demonstrated to improve equity, reduce barriers to care, and provide essential promotive, preventative, curative services in an effective and cost-effective manner.[3]

Impact analyses of investments in community health in 15 priority countries have shown that well-supported community health programmes have the potential to save over half a million lives in the next decade in those countries.[4]

UNHCR's goal is for refugees and other persons we serve to access the preventive, promotive, curative, palliative, and rehabilitative health services they need, at an affordable cost and of sufficient quality to be effective to lead healthy and productive lives. UNHCR promotes the delivery of public health programmes for refugees, asylum seekers and advocates for stateless, returnees and internally displaced persons based on the principles of PHC; people-centred rather than disease-centred; using a whole-of-society approach; and providing care in the community as well as care through the community.

With the goal to 'leave no one behind', community health approaches excel at connecting with hard-to-reach and vulnerable groups such as adolescents, pregnant women, children, persons living with human immunodeficiency virus (HIV), and persons with disability. Equally, in humanitarian contexts, a community health approach has been found to provide lifesaving health access and information during emergencies when routine infrastructure, health and social services may be compromised.[5] In refugee contexts, the CBHW, as refugees themselves, serves as a crucial cultural and linguistic link between the community and health and other service providers.

1.4 Structure of the document

This document is organised around the main health system components that are essential to community health programming:

- Programme design considerations (integration and linkages to primary health systems, community ownership, considerations for humanitarian contexts, and inter-sectoral collaboration or integration)
- Human resource considerations
- Referral systems
- Financing, equipment and supplies
- Monitoring
- Service delivery interventions and approaches across the life span with recommendations for priorities for both emergency and post-emergency/ protracted settings

2. Community health programme design considerations

2.1 Guiding principles and approaches

Community health programmes should be designed from a rights-based approach and led by communities. Well-designed and well-implemented programmes will have a direct impact on family's health, nutrition and overall well-being and can contribute to better education and livelihoods outcomes, thereby strengthening overall protection outcomes. Community health programmes should be designed taking into consideration the following protection principles:

- 'Do no harm' that actively avoids exposing refugees to potential negative effects from one's actions.
- UNHCR's community-based approach is at the heart of community health interventions and emphasises mobilising individuals, families and communities and building on their existing knowledge, skills, and capacities.
- The rights-based approach promotes the respect for rights at both individual and community levels as well as the change needed to fulfil these rights.
- UNHCR's Policy on Age, Gender and Diversity ensures that all segments of the population have equitable and non-discriminatory access to assistance and protection.
- UNHCR's data protection policy seeks to protect the rights of individuals whose information it holds, and to ensure that the processing of personal data conforms to key data protection principles.
- Protection mainstreaming incorporates protection principles throughout the programme cycle and promotes meaningful access with safety and dignity for all populations.
- Accountability to Affected Populations is a commitment to the systematic inclusion of the expressed needs, concerns, capacities, and views of persons of concern in all their diversity; and being answerable for organisational decisions and staff actions.

2.2 Programme design

Community health programmes should be based on a strategic approach as part of an overarching public health strategy and should include health protection, health promotion, prevention, curative, and rehabilitative components across the life course. Programme designs will be context-specific and require a strong enabling environment, which involves being:

- Adapted to the local context including phase of emergency, epidemiology and community priorities.
- Well-integrated within the PHC system with CBHW roles linked to health facilities in a systematic and collaborative manner.
- Deeply embedded in and supported by the community it serves.
- Strongly focused on health protection, promotion and prevention activities and based on a SBCC strategy.
- Focused on reducing inequities and being responsive and accessible to particular at-risk groups.
- Multi-sectoral, considering the social determinants of health and taking a coordinated approach across sectors for community outreach activities.
- Supported by strong management and leadership to ensure quality services.

- Sufficiently funded and prioritised as an integral part of a cohesive public health response.
- Having a cohesive monitoring plan.

The specific design and components of the programme will be informed by a situational analysis.

2.3 Situational analysis

When setting up a new programme or deciding if existing programmes need to be strengthened or modified, it is useful to conduct a situational analysis in close collaboration with the Ministry of Health (MoH) and other partners, PHC providers, and community members, with a focus on identifying supply and demand-side barriers to accessing health care effectively. Important information to inform the design or strengthening of a community health programme include the following:

- National policies, protocols and guidelines related to CHWs and other CBHW cadres, including scope of practice and linkages to other levels of health care.
- Type of humanitarian setting, phase of displacement, population movements; local risks and hazards; socio-demographic and environmental considerations.
- Local epidemiological context including main causes of morbidity, mortality, immunisation coverage, malnutrition prevalence, living conditions, water and sanitation conditions; epidemiological surveillance and other community health information systems in place.
- Availability of and access to primary health facilities (including distances, transport, security barriers, current functional capacity, cost).
- Gaps in the continuum of care for priority conditions, including inequities in coverage across the population; needs of underserved groups.
- Health knowledge, attitudes, and practises, health seeking behaviour in the community, including barriers and enablers related to trust in the health system, gender, culture and language.
- Community perceptions, needs and priorities.
- Available financial, human, and material resources, including community capacities.
- Other types of community outreach workers active in the same community and their roles (e.g., from other sectors/ sub-sectors such as nutrition and WASH).
- Security context including security risks that may impact travel and service delivery for both community members and CBHW.

Based on findings of the situational analysis, identifying priority areas of interventions and cost-effective solutions and developing a costed operational plan are key next steps.

2.4 Integration with national health systems

The Global Compact on Refugees promotes the integration of refugee health services into national public health systems wherever possible and integration and cooperation with the broader health system has been found to be a key enabler of CHW programme success.[6] While many countries have community health policies or guidelines in place, consistent implementation may vary at sub-national level. In both refugee and national contexts, community health programmes often continue to be provided by a multitude of non-governmental actors, resulting in parallel programmes with different implementation foci, funding and reporting mechanisms.

Integration into existing national community health programmes is not 'all or nothing', and the degree of integration may vary for different programme components (governance and leadership, financial resources, human resources, service delivery and data).

For example:

Fully integrated

Fully integrated refugee community health programme entails that its workforce is funded, trained, accredited, and supervised by the MoH in accordance with national guidelines and policies and data collection and indicators are integrated with government health information systems.

Partial integration

Partial integration can take different forms depending on which programme elements are integrated (e.g., CHWs trained by MoH, trainings using MoH guidelines or being accredited by MoH but financially supported and supervised by partners).

No integration

No integration refers to refugee community health programmes that function outside of existing national community health systems (or countries where no policies/ guidelines exist); use adapted training curricula, terms of reference, and payment, with separate data reporting system.

Working towards increased integration with national health systems may include the following actions by UNHCR and its partners:

- Review **national policy** including any national or sub-national CHW programmes and the status of those programmes and advocate for the inclusion of refugees in national CHW programmes where feasible, including the inclusion of refugees in the national CBHW.
- Where feasible, provide **financial, technical, or material support** to national community health programmes operating in refugee settings to strengthen them and integrate refugees instead of creating parallel programmes.
- Actively collaborate with relevant members of the MoH to **align standards** of recruitment, remuneration, competencies, training content, certification and accreditation, scope of practice, communication and reporting lines, data collection and analysis. Where alignment isn't feasible or policy does not exist, MoH agreement should be sought whenever possible.
- Participate in the development of a **shared monitoring and reporting system** and make data collected from community health programmes available to relevant health authorities.
- Establish **accountability mechanisms** for CBHW programmes that link to and communicate with local government authorities.

2.5 Linkages to primary health facilities

Community health programmes are an integral part of the PHC approach and programmes. Regardless of the level of integration, community health programmes should be linked to primary health facilities to be effective. This may include the following:

- The CHW supervisor is a core part of the **primary health facility management team** and should have regular meetings with primary health facility management to develop shared objectives and work plans, provide situation updates on the community health programme, review data, and coordinate patient follow-up.
- A **viable referral mechanism** between the CBHW and the PHC facility, including standardised feedback and a method for two-way communication between CBHW and the primary care provider.
- Community-based surveillance (CBS) and CBHW monitoring **data** should feed into health information systems including any existing Early Warning and Response System (EWARS).

- Medical **equipment and supplies** needed for community health programmes should ideally be integrated into the PHC facilities procurement and pharmacy systems.
- Consider engaging CBHW members to provide SBCC in the PHC facility to foster integrated activities.
- Linkages in **urban programmes** may be less well developed, especially where the CHWs are not fully integrated in the national system. At a minimum, CHW members should be knowledgeable about available health services and how to access them to facilitate effective referrals, have a regular rapport established with PHC facilities and support CBS as part of the national system.

2.6 Community engagement and ownership

The **community** itself is an **integral partner** in the governance and leadership of community health programmes. **Community engagement** is a core principle of community health programmes, which involves empowering social groups and their leaders, including traditional, community, civil society, government, to build on their current capacities and strengths to actively participate in decision-making on matters that affect their lives. This includes community participation in design and implementation of programmes, fostering ownership and empowerment, ensuring inclusion of vulnerable groups, establishing two-way communication and building on local capacities and resources.[7] Effective engagement of host communities and refugees can furthermore foster social cohesion in refugee contexts.

Community engagement should be sought throughout the phases of programme planning, implementation, monitoring and evaluation. This may be done through the active involvement of community leaders, women and youth groups, refugee health committees, organisations of persons with disabilities, LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex and queer and other diverse identities) groups, persons living with HIV and others, ensuring that voices of vulnerable groups are heard. Community members may:

- Support identification of priority health problems and guide the development of community health action plans and health messages.
- Mobilise relevant local resources and stakeholders related to community health such as political, religious, and civil society organisations.
- Participate in the selection of CBHW members, support them in their daily work and monitoring their performance.
- Participate in CBS activities, amongst other activities.
- Steer the oversight and management of the programme through participation in refugee health committees or similar.

Based on their first-hand experience, CBHW members, along with related community-based organisations are well-placed to advocate for improvements in essential services, improved access to services for vulnerable or key groups and policy changes.

Community engagement approaches

Improving health at the community level requires effective community engagement and SBCC approaches. SBCC aims to address the barriers and determinants of behaviours at various levels, including:[8]

- **Individual:** related to the knowledge, attitudes, beliefs, and emotions of individuals.
- **Family and peer groups:** an individual's behaviour is influenced by their close social and family circles.
- **Community-level:** influence of leadership, access to information, services, and social capital.
- **Societal/ Structural:** The macro-environment that can promote or deter behaviours including the physical environment; available resources and services; laws, policies, and protocols; religious and cultural values; media and technology; gender norms and income equity.

© UNHCR/ Mary Sanyu Osire

SBCC aims to help individuals and communities know, select, and practice behaviour that will positively impact their health. Programmes are recommended to be based on assessments and address each of the above levels, using **advocacy, social mobilisation**, and **interpersonal communication approaches.**

Key components of SBCC for the CBHW include:

- **Community mobilisation** around a health topic requires engagement with key gatekeepers (community and religious leaders, educators, politicians, social and peer influencers). Supporting participatory action and peer support groups or networks is also an important method of community mobilisation (see Box 1).

- Effective **interpersonal communication** at the individual, family, and group level is a vital skill set for the CBHW. This includes principles of active listening, two-way communication, providing relevant information based on individual circumstances, understanding non-verbal communication, conflict resolution and problem solving.
  - CBHW members should be trained in effective interpersonal communication skills and supervisory visits should include ongoing support to develop those skills further.
  - The development of relevant information, education, and communication (IEC) materials for the target audience should be done in partnership with the community, and use a multi-sectoral approach, to ensure all stakeholders agree and use the same key messages. Existing national materials should be used where available with adjustments in language and cultural context as required.
  - Different messages or approaches will be necessary for different sub-groups of the population (e.g., adolescents, older persons, persons with disabilities).

- Consider the **communication channels** that can best reach the target audience, that are accessible to different members of the community and are the preferred channels of the community; a combination of methods is required to reach all population groups:
  - Household visits provide the opportunity to give targeted support to families based on their individual needs.
  - Community-level activities (meetings, discussions, participatory or support groups etc) conducted in community locations including schools, workplaces, religious and social venues.
  - Helpdesks for general information and community centres are a key opportunity to reach refugees through other sectors. Hotlines are particularly useful in settings with widely disbursed or mobile refugee populations. Developing regularly updated FAQs on health issues and access to health services is critical to ensure colleagues operating those services can provide basic information and link refugees to relevant services.
  - Social media, e.g., web-based information platforms or messaging apps provide opportunities to reach a wider audience. They are effective in sharing health messages but don't offer opportunities to engage further, consider adding contact details for further direct engagement where feasible.
  - Creative channels such as theatre, drawing (e.g., art murals), films and music enable raising health matters from a different viewpoint and can be combined with guided discussions.
  - Sharing information through otherlocally relevant media such as posters, megaphones, pre-recorded messages on motorbikes and other vehicles.

- During **public health emergencies and disease outbreaks**, risk communication and community engagement **(RCCE)** approaches require additional considerations. This includes clear and consistent health messaging across all levels to inform the public of the health threat, how they can protect themselves, and steps to counter dis- and misinformation through, for example, rumour tracking.

Box 1: Examples of participatory approaches

Participatory Learning and Action Women's Groups. Participatory learning and action groups are recommended by the World Health Organisation (WHO) to improve maternal and newborn health, particularly in rural areas with low access to health services.[9] A systematic review of participatory learning and action groups for women in rural, low-resource settings found that with sufficient coverage they improved newborn and maternal health outcomes and were highly cost-effective.[10] Through a facilitated group, women are supported to identify priority problems and develop local solutions. For health impact, groups should be facilitated by a trained facilitator, ensure adequate population coverage, and continue for at least 3 years.

École de Maris **or "Husband's School"** is a participatory men's group that promotes reproductive, maternal, newborn and child health and nutrition. Recognising the important decision-making role of men in many cultures on their family's care-seeking behaviours, this group uses volunteer men who are trained and supported to mobilise their peers on key reproductive and maternal, newborn and child health related actions.

Peer Support Groups and Networks: Mother-to-mother support groups are a model in which individual mothers are trained to lead a peer group. Groups are typically led by two trained mothers and are venues to discuss topics around pregnancy and childbirth, child health and nutrition. Health staff or CHWs provide ongoing support and capacity building to the lead mothers to expand topics over time. Other peer support group examples include mentor mothers for pregnant women living with HIV; peer educators for adolescent sexual and reproductive health (ASRH); support groups for people with specific medical conditions such as diabetes.

2.7 Community health approaches

A well-functioning community health programme is a vital asset in emergency preparedness and response as well as during the transition to the post-emergency phase. During new displacements, community health programmes often need to be rapidly scaled up or newly established where none exist. During other types of emergencies, such as natural disasters or communicable disease outbreaks, community members are often the first to respond during emergencies. Experience in various types of humanitarian settings has demonstrated that, with support, CHWs can continue to provide services during emergencies, and in some cases, they may be the only health providers who still have access to affected populations.[11, 12, 13]

Specific priority actions for each health intervention type during both the emergency and post-emergency phase are outlined in ***Section 7: Service Delivery***. Programmes need to adapt a flexible approach to community health and adapt to the changing disease burden, including switching to outbreak control where communicable disease outbreaks occur.

The following elements of CBHW programmes are recommended to be in place to facilitate routine work and emergency response:

- Ensure maps of CBHWs' location and supervisors, including population coverage, are developed, regularly updated and shared with partners.
- Identify persons at heightened risk (e.g., older persons, persons with disabilities or chronic conditions, pregnant and lactating women) who may require additional community health support, including during/after emergencies.
- Ensure that community health actions are an integral part of emergency and outbreak preparedness and response plans, community health supervisors are part of preparedness and response taskforces, key health messages for potential threats are developed, stocks are available in the community (e.g., oral rehydration salts (ORS)) as well as personal protective equipment (PPE) for CBHW.
- Establish a CBS including early warning and response for key diseases, linked to other reporting systems (*see* ***Section 7.6***).
- Establish referral procedures, including alternative transport and communication protocols.
- Train CHWs in basic first aid, Psychological First Aid, standard health messages and surveillance.

Specific actions during emergency response include:

- In situations of new displacements without existing community health systems, the initial focus will be on rapidly selecting and training CHWs on priority interventions.
- In situations of natural disaster or extreme weather events affecting existing refugee populations, analyse the situation in affected areas, including functional status of any health facilities, health personnel, security context, ability of CBHWs to perform key tasks. CBHWs may be affected themselves and may not be fully functional.
- Communicate key information to community members using standard messages and provide feedback on major health incidents to health facilities.
- Focus on maintaining priority interventions (e.g., first aid and referral, CBS, outbreak response).

CBHW members may be confronted with distressing events when carrying out their duties. Include training on stress management and self-care in standard training packages and ensure access to psychosocial support for CBHW members.

2.8 Inter-sectoral collaboration and integration

Where the CBHW is not fully integrated with national community health programmes or national programmes do not exist, each sector may have its own cadre of community outreach workers, with potentially overlapping areas of intervention between health, WASH, nutrition and mental health and psychosocial support (MHPSS). This may result in repeated home visits, conflicting messages, community fatigue and ineffective use of human and financial resources.

UNHCR aims to align with national programmes and work towards integration of the CBHW into national programmes. Where this is not yet fully achieved or not yet feasible, UNHCR aims for a harmonised community-based workforce where CHWs are at the core of community health interventions and take a holistic approach to health, hygiene and nutrition promotion at household and community level *(see **Box 2**)*. CHWs will assess households' capacities and needs and engage with refugees based on their individual needs as well as discuss messages relating to the overall programme priorities (e.g., during disease outbreaks).

Depending on the context, they may be complemented by other sectoral/ sub-sectoral cadres (*see **Annex 1***):

- **Hygiene Promotors (WASH):** CHWs will engage with families on hygiene promotion, including hand hygiene, safe drinking water, sanitation and food hygiene. Complementary, hygiene promoters take a lead in community mobilisation and engagement in e.g., WASH facility design and construction or water committee establishment and engagement and, where agreed at operational level, manage behaviour change on WASH related topics (e.g., hand hygiene, safe water, latrine use). During outbreaks of waterborne diseases additional complementary activities of hygiene promoters may include cleaning of jerry cans at water distribution points or support in latrine disinfection.
- **Nutrition:** CHWs will promote appropriate infant and young child feeding (IYCF) practices, promote growth monitoring, screen for malnutrition and follow-up on nutrition programme defaulters. Nutrition outreach workers will foster family and community capacities by e.g., facilitating mother-to-mother support groups or conducting targeted follow-up of children that fail to thrive. Situations with global acute malnutrition (GAM) rates above 10% require a strong focus on prevention of malnutrition and identifying and referring malnourished children. In such situations nutrition outreach workers will be engaged in promoting ICYF and screen for malnutrition at home in this situation. In addition, the focus of the CHW outreach activities and the number of CHWs can be increased to ensure all tasks are covered.
- **MHPSS:** CHWs will identify, refer and follow-up people with mental health conditions and provide key messages on healthy coping styles. MHPSS worker will provide supportive psychosocial interventions, brief psychological interventions, targeted support to people with severe mental health conditions and their families. During emergencies, both cadres will provide Psychological First Aid.

In situations where tasks are overlapping between different cadres of community workers, strong coordination, close collaboration, and awareness of the technical and programme issues of each sector are essential for harmonised programming **while working simultaneously towards an integrated approach.** Key actions related to **inter-sector coordination** at the community outreach level include:

- Hold regular **inter-sectoral community-outreach coordination meetings;** identify opportunities for joint planning and monitoring of activities to harmonise implementation and identify opportunities for mutual support.
- Develop standardised and **coordinated messages across sectors and conduct joint trainings.**
- **Map outreach workers** from all sectors to ensure all geographical areas are covered equitably and ensure that those working in the same area **know one another** and are familiar with each other's role and responsibilities.

The stepwise approach to a harmonised workforce may be facilitated by the following actions:

- Advocate for **inter-sectoral integration** at the national and sub-national level.
- Work towards **buy-in from decision makers** by highlighting the benefits of an integrated approach, including a) impact on key outcomes such as mortality and morbidity; b) cost-savings and c) enhancing efficiencies.
- Develop **task teams**/ coordination bodies at multiple levels to guide integration efforts with designated lead agency.
- Engage sectoral partners in **joint training** and supervision.
- Consider **creating collaboration agreements** between sectors.

Strong coordination at all levels will need to be established with protection, education and other sectors to embed the programme in the wider protection approach and framework as well as to ensure effective referral to address refugees' wider needs.

Box 2: Inter-sector integration of community outreach roles

In Cox's Bazar, Bangladesh, the **UNHCR-led Community Health Working Group** worked together with key stakeholders (MoH, UN, NGOs and communities) to develop a strategy to integrate nutrition and health activities in four pilot camps in 2021. In this case, integrating nutrition and health community outreach activities was one part of a broader inter-sectoral integration across primary care services. The new outreach role is called Community Health and Nutrition workers. Integration included the following steps:

- Ensuring enough preparation time (> 1 year) to align sector objectives, proposals and budgets.
- Identifying a partner who can provide both health and nutrition services.
- Integrating nutrition and health services within the same primary health structure.
- Determining shared community-based indicators and developing monitoring tools.
- Developing new terms of reference for community health and nutrition workers and adjusting the population covered per community health and nutrition worker to account for their increased responsibilities.
- Training CHWs on additional nutrition-related tasks.

3. Community-Based Health Workforce (CBHW)

The CBHW may include CHWs, trained workers/ volunteers such as peer educators, and lay health providers such as TBAs and traditional healers who have been mobilised to support formal health services. Defining the roles and responsibilities of each cadre, establishing standards for recruitment, remuneration, training, accreditation, supportive supervision approach and feedback mechanisms are key human resource considerations.

3.1 Role definitions and considerations

Community Health Workers (CHWs)

Evidence supports a wide range of potential interventions for CHWs in health protection and promotion, prevention, curative, and rehabilitative roles, with the scope of practice varying widely based on local context.

SPHERE recommends a minimum ratio of **1-2 CHWs per 1000 population** in humanitarian settings; requirements will be determined by the following factors:[14]

- Expected workload based on local epidemiology and priorities
- Frequency of contact required
- Number and complexity of services provided
- Weekly time commitment (including time allotted for trainings, administration, data collection and reporting)
- Geography including time to reach households and health facility, security, and travel restrictions
- Financial and human resources available

Complex tasks including diagnosis and treatment require a strong **enabling environment** for CHWs including training, accreditation, reliable supply chain and supervision to ensure these tasks are done correctly and safely.

Peer educators

Peer education mobilises motivated and well-trained community members from different groups to lead organised educational or health promotional activities with people close to them in age, background or interests (peers). Peer education aims to develop peers' knowledge, attitudes, and skills, enabling them to be responsible for and protect their own health.[15] They are often more accessible to populations that may face social and structural barriers to accessing formal health services (e.g., adolescents/ young people, people living with HIV, individuals engaged in selling or exchanging sex). Peer educators may be volunteers or paid, as all CBHW members they require training, ongoing support and supervision to remain effective. An integral part of their role is to refer those in need of further support to health service providers. Evidence on peer educators' effectiveness in health promotion aspects is mixed if they are unpaid, consider using a combination of approaches of different CBHW members for wider impact.

Traditional Birth Attendants (TBAs)

Use of TBAs is common in many settings where UNHCR works. Where women continue to use TBAs for home births despite available, accessible, and quality skilled birth attendant services, a situational analysis may be helpful to understand their current role in the community, community perceptions and practices, and reasons for their use including existing barriers to formal health services. Agreeing on alternative roles for TBAs through dialogue with TBAs, women, families, communities, and service providers is an important first step in mobilising TBAs to support skilled birth attendance and

uptake of other maternal, newborn and child health interventions. Transitioning existing TBAs for a different, non-clinical role will require training to strengthen TBAs' knowledge and skills. In addition, it is important to create linkages with public health facilities to foster integration as well as the sensitisation of health providers, communities, women, and their families to ensure a successful transition.

Other CBHW cadres

Other CBHW cadres may include trained volunteers such as Red Cross/ Red Crescent volunteers; peer group leaders; health committees; community-based distributers of family planning; traditional healers or others who have been mobilised to assist in specific tasks such as referrals and community-based surveillance.

3.2 Recruitment

The following should be considered when recruiting CHWs and other CBHW members:

- Prior to recruitment, role expectations should be outlined in written **terms of reference** including responsibilities and tasks, location, working hours and conditions, and benefits such as financial and non-financial remuneration. Key requirements should be outlined including level of education, numeracy, gender considerations, literacy and language skills, personal attributes and interpersonal skills (*see **Annex 2***). Special considerations on nationality or ethnicity may be required for programmes serving host community and refugees. Recruitment announcements should be accessible to all community members, including those with limited literacy and those with disabilities.
- Recruitment should be based on transparent, impartial, and non-discriminatory processes, taking into account age, gender and diversity. A process should be in place for **community participation** in recruitment, ensuring the person selected is appropriate and acceptable to the community, taking care to avoid any further discrimination of specific groups.
- **Gender equity** and community perceptions on gender should be considered during recruitment. Some topics related to sexual and reproductive health (SRH), pregnancy and gender-based violence (GBV) may be more culturally appropriate for a provider of the same gender. At the same time, there may be contextual or cultural constraints limiting women's potential for participation. Appropriate adjustments and mitigating measures should be undertaken to enable meaningful and equal participation of women in the community. This may include, for example, engaging female CHWs to work within the community they reside in, moving in pairs or creating women's volunteer groups.
- Note that **literacy requirements** in areas where female literacy is low can lead to gender imbalances in employment. Workers or volunteers who are not literate can perform well when adapted approaches are provided, such as the use of pictograms, tally sheets and check-off systems for reporting.
- A minimum level of vetting candidates is recommended; this includes systematic gathering of the basic information about such individuals, and background checks against previous volunteering/ employment records and/ or criminal records, as applicable. The checks should include questions about any previous incidents of misconduct.
- It is recommended to sign a **contract** based on the terms of reference between the CBHW member and the recruiting entity (MoH, NGO) as well as a Code of Conduct that includes a clause on commitment to Prevention of Sexual Exploitation and Abuse (PSEA). UNHCR funded partners will need to provide such supporting documents as part of their PSEA capacity assessment.

3.3 Remuneration and incentives

Research shows that **adequate financial compensation** is a key factor in motivating and retaining CHWs and supports the effectiveness

and sustainability of community health programmes,[16] with the highest performing CHW systems being ones in which CHWs are formalised, paid, and given other appropriate incentives.[17] Lack of adequate remuneration may lead to frequent turnover of trained staff, poor motivation, and increased costs for recruitment and re-training of staff.

The Global Compact on Refugees promotes refugee self-reliance through active participation in social and economic life of the host country, including access to decent work. Providing financial compensation to full-time CBHW members is in line with the Global Compact on Refugees and supports achievement of the SDGs related to promoting decent work and economic growth (SDG 8) and gender equality (SDG 5).

UNHCR advocates for CBHW members to receive adequate financial compensation in line with job demands, hours worked, complexity, training and roles that they undertake, in line with WHO recommendations.[15] Challenges around financial remuneration in refugee settings are common and may include legal restrictions on the right to work and paid employment for refugees; national health policy that designates CHWs as volunteers; limited institutional funding and/ or a patchwork of different incentive payments across agencies and roles, leading to dissatisfaction and attrition. Efforts should be made to overcome these barriers towards a fair and equitable payment for workers. Relevant actions include:

- **Advocate** to donors, governments, partners and internally within UNHCR to secure fair remuneration.
- Align incentives with national standards set by MoH or other relevant entities for similar cadres if tasks are comparable. Where the programmes are not fully aligned or integrated with MoH, incentives for the CBHW should be **harmonised** across agencies, partners as well as across sectors engaging other community-based workforces.
- Provide a **balance of both financial and non-financial incentives.** Financial payments are recommended to be commensurate with hours worked, level of training, and complexity and demands of the roles undertaken and in line with the local market. Those expected to work **full-time** should receive **financial remuneration** instead of non-financial incentives whenever possible. If monetary payment is not possible due to legal restrictions on employment of refugees in the host country, equivalent in-kind payments should be provided. The use of unpaid volunteers should be restricted to contexts where the work is limited to a few hours per month.
- **Non-financial incentives** proven to be motivating include a supportive work environment including respect from the community and public recognition of one's work, opportunities for career advancement and adequate personal protective gear and visibility.
- **Performance-based incentives,**[18] if used, should not be the primary means of remuneration but may be used in addition to other payments.

3.4 Training and accreditation

Pre-service and ongoing training of the CBHW is important to ensure interventions are being carried out effectively. It furthermore increases motivation and job satisfaction, as well as increasing the community confidence in the CBHW. A system of accreditation is also important, which should include multiple methods of assessing skills and knowledge. This should be done before starting work and re-assessed at regular intervals.

It is recommended that training is conducted by MoH, using MoH curricula and facilitators to support accreditation and integration within the national system where feasible. Engagement should be sought with education and other relevant units within UNHCR to explore further career pathways for refugees to vocational/ professional education within the national health system.

© UNHCR/ Pauline Omagwa

General guidelines for **training** include:

- Develop context specific training/ facilitation guide based on WHO competency modules (*see **Box 3***) as well as accompanying health promotion materials, translated in relevant languages. Issues around infection prevention and control, self-care and stress management should be included under the module for personal protection.
- Engage with protection and other sectors for the systematic inclusion of cross-cutting themes in trainings such as GBV, including safe disclosure, confidentiality, code of conduct and PSEA, related referral pathways and where to report any concerns.
- Involvement of **clinical health staff** from the primary healthcare facility level in trainings and supervision can help improve quality of care.
- Use both classroom and field training components; use an active and participatory approach rather than lecture (e.g., role play, drama, case studies, group work, etc.). Adapt methods to accommodate trainees with limited literacy, including usage of pictorial aids and audio-visual materials.
- Provide follow-up training with mentorship and/ or increased supportive supervision immediately after training to ensure learnings are being correctly implemented in practice.
- Regular **refresher training** should be scheduled throughout the year and whenever a new intervention is added to the scope of practice. Use regular weekly or monthly meetings for short refresher sessions.

Numerous opportunities exist for **e-learning** with online short courses on specific topics. *See **Annex 4*** for sample e-learning and other courses for the CBHW.

Box 3: WHO recommends the following core competency modules for CHW training[15]

- Promotive and preventive services, identification of family health and social needs and risk
- CHW's role within the wider health care system including referral, patient tracing, collaborative relation with other health workers in primary care teams
- CBS
- Monitoring: data collection, analysis, and use
- Social and environmental determinants of health
- Basic psychosocial skills
- Interpersonal skills related to effective communication, community engagement and mobilisation
- Ethics, including confidentiality and data protection, protection principles, and PSEA
- Personal safety (including infection prevention and control)
- Diagnostic, treatment, and care in alignment with expected role(s) and applicable regulations on scope of practice

3.5 Supportive supervision

Supportive supervision is a key factor to ensure community health work is carried out correctly and effectively. Supportive supervision should focus on worker's knowledge and skills, motivation, and adherence to correct practices. Evidence suggests that *quality* of supervision is more important than quantity; regular field supervision visits are critical; and supervisors often require training and support to develop problem-solving and coaching skills themselves.[19] Supervision should be based on a collaborative approach (*see* ***Box 4***), focused on constructive feedback rather than fault-finding, and an appropriate supervisor-to-supervisee ratio must be assured to allow for regular observation of work.

- A ratio of one supervisor : 10 supervisees is recommended, to be adjusted based on responsibilities, available resources, and distances to travel for supportive supervision.
- A supervisor training programme should cover both technical health topics as well as effective communication, leadership, and management skills.
- A detailed **terms of reference** should be established outlining the core skills, competencies, and responsibilities of the supervisor. Key responsibilities will include:
  - ✔ Lead knowledge and skill development of CBHW members
  - ✔ Shadow visits with CBHW members during home visits and other activities
  - ✔ Act as a liaison between the PHC facility, other sectors and CBHW members
  - ✔ Collect and collate weekly data, analyse, and feedback to workers, primary health team and community
  - ✔ Ensure adequate supplies and equipment are in place
  - ✔ Provide performance reviews by assessing the quality of work through supervisory observations and community feedback

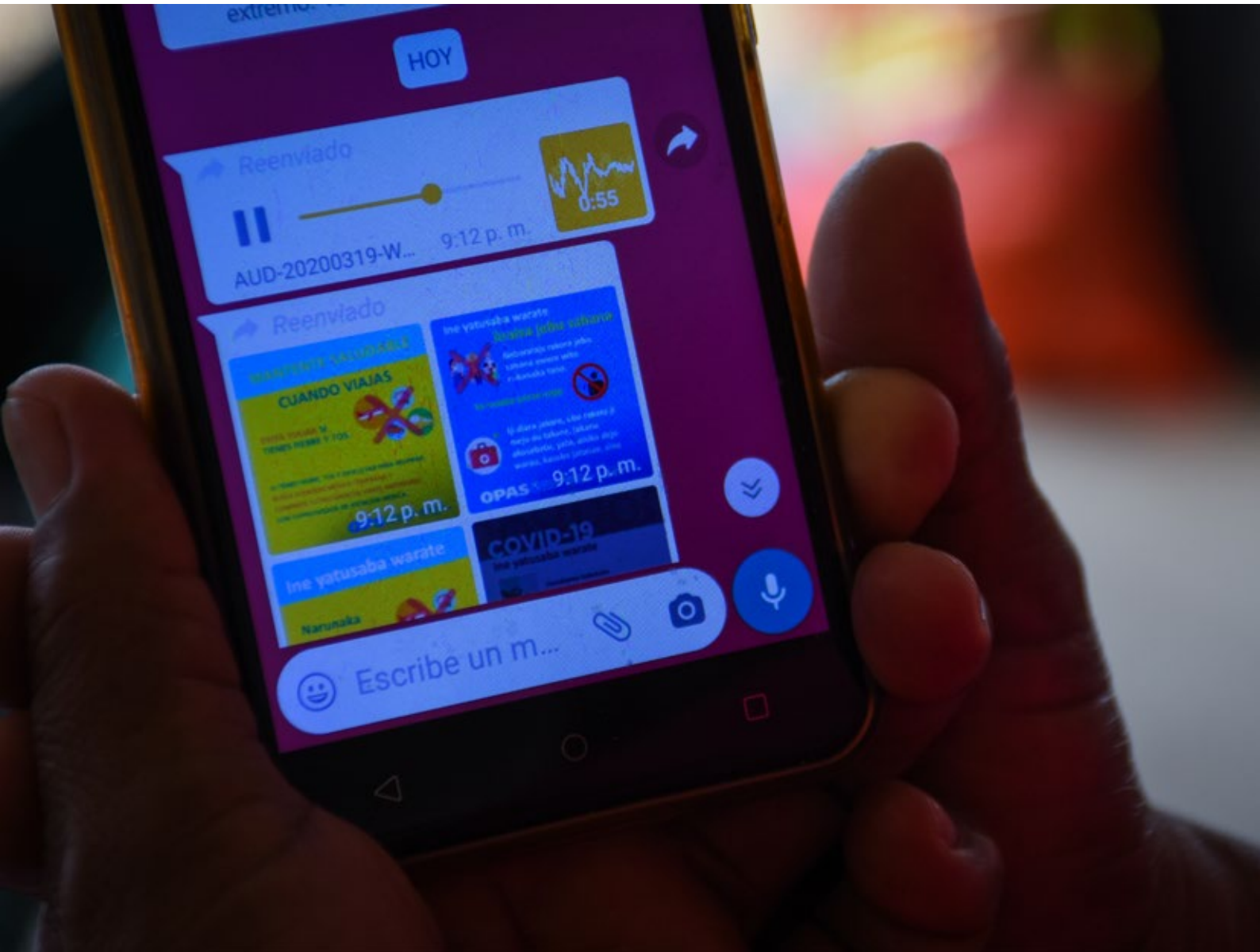
Box 4: Effective supervisory approaches include:

- Regular group meetings between supervisor and supervisees to problem solve and set goals.
- Supervisor directly observes work including home visits and uses supervisory checklists coupled with targeted feedback on areas for continued improvement.
- Foster peer support by pairing stronger CBHW members with less experienced ones and through other informal exchange networks such as WhatsApp groups.
- Use of peer-to-peer and/ or self-assessments with results shared with supervisor.
- Assessing CBHW performance through community feedback.

Additionally, communities need to be able to provide feedback on CBHW members in a confidential and safe manner based on communities' preferred communication channels.

Mechanisms need to be in place to ensure information is stored, analysed and responded to accordingly. Existing feedback and response mechanisms should be used wherever possible to avoid multiple parallel systems and should be made known to community members.

© UNHCR/ Allana Ferreira - Members of Venezuela's indigenous Warao refugee community receive health messages on their phones.



4. Referral system

A key part of community health workforce responsibilities is to identify persons in need for additional support in the community and refer them to primary health services or linking with other services such as rehabilitative services (including assistive devices),[20] nutrition, MHPSS, protection and basic services such as shelter, WASH and cash assistance if criteria are met. A functional referral system is a key priority in setting up and strengthening community health programmes. Barriers to referrals in refugee settlements may include lack of trust in formal health services, unfamiliarity with the health system and/ or health facility locations, sociocultural barriers or competing demands (e.g., other children at home). Additional barriers in non-camp settings may include limited primary health service availability/ functionality, financial barriers and security constraints. Key referral-related actions at the community level include:

- **Map health and social services, develop sectoral referral pathways** and ensure all CBHW members are aware of the closest facilities and the services they provide. In emergency contexts these will need to be **updated regularly** due to frequent changes in service availability.
- Clear guidelines and **standard operating procedures** for referral should be in place, including a standardised referral form (*see **Annex 3*** for sample referral forms) and ensuring a counter-referral system is in place (e.g., for communication from health facility back to CBHW member for follow-up visits).
- Engage with community members to develop community-led, last-mile solutions such as stretchers, bicycle or motorcycle ambulances to reach health facilities.
- Use CHWs' capacities to overcome, for example language barriers by supporting translations in health facilities, especially in urban areas where this may not be covered through health facilities.

Safe disclosure of GBV

Survivors of GBV may disclose to a CBHW member and seek their support. CBHW members must be trained on how to safely handle a disclosure, respond in a supportive, non-stigmatising, survivor-centred manner and make a referral in line with the GBV referral pathways.

© UNHCR/ Esther Ruth Mbabazi - A CHW tests a refugee for malaria in Nakivale Refugee Settlement, Uganda.

5. Financing, equipment and supplies

Financing

The community health component of primary care should be included systematically in health budgets, proposals and appeals in line with UNHCR's programme management cycle. Community health programmes often face operational challenges due to funding shortages. This can result in cuts in training, reduced number of CBHW members and breach in supply chains which may lead to a reduction in services, reduced supervision and loss of confidence of the community.

Providing an overview of both costs and benefits of community health programmes can assist in mobilisation of resources and appropriate allocation of funding. Include evidence generated from regular surveys and ongoing monitoring to demonstrate the impact of ongoing community health programmes in proposals, including, for example, increased immunisation coverage or improved knowledge on priority health topics.

Equipment and supplies

A reliable supply chain is important for community health programme quality and success. Limited availability of needed supplies at both the community level and the primary health level may undermine both the acceptability and effectiveness of the community health programme. The supplies required will be determined by the priority interventions of the programme and the related terms of reference of the CBHW member, situation specific replenishment standards need to be agreed upon. Depending on the situation, supplies may include personal protective equipment, protective gear (e.g., gum boots, raincoats), first aid kits, stationary, IEC materials including pictorial job aids, visibility items, mid-upper arm circumference (MUAC) tapes as well as medicines and medical supplies and others.

Where medications and medical supplies are provided to CHWs, essential pharmacy management principles should be applied, including the following key actions:

- Medications and medical supplies should be part of national or UNHCR's **Essential Medicines List** and approved for use by the specific cadre within national health policies. Procurement should be integrated in the overall medicine procurement system, following UNHCR's Essential Medicines and Supplies; Policy and Guidance.
- **Trainings** should include content on dispensing practices, basic storage, stocking and waste management. CHWs should maintain and submit **monthly medicine stock reports** on usage and inventory to aid regular replenishment. Supervisors should review registers and cross-check inventories to avoid ruptures and promote sound medicines management.

In addition to medical equipment and supplies, use of various low- and high-tech tools can improve quality and efficacy of care. **mHealth** (mobile technology including phones, tablets, or other) is increasingly used to assist with diagnosis, communication, reminders, monitoring and reporting. Where introduced, an analysis of potential security risks should be conducted and safe-keeping measures need to be considered in planning as well as ongoing costs such as phone/ connectivity charges. Other low-tech options include:

- Counting beads to support assessment of rapid breathing in newborn or children
- Pictorial instruction cards for rapid diagnostic tests
- Pictorial health education cards
- Checklists and standard record forms (referral forms, registers, etc.)

6. Programme monitoring

CHWs and other CBHW members play an important role in collecting data at community level and often fill a crucial information gap. Integrating relevant data into national or local health information systems is critical to support planning, monitoring and evaluation of public health interventions.

An actionable, results-oriented **monitoring plan** is a key component of community health programmes. The following should be considered when developing a monitoring plan and choosing indicators:

- Identify and engage **key stakeholders** throughout the process of planning, data collection, analysis, and dissemination.
- **Align and integrate indicators and reporting** with national or district community health information system, district health information system (e.g., DHIS2) and/ or the integrated refugee health information system (iRHIS) as well as across sectors.
- Conduct baseline and regular follow-up **surveys** to monitor changes in knowledge, attitudes and behaviour amongst refugees, measure impact and adjust community health programmes based on the findings. Where possible, integrate relevant questions in other surveys such as UNHCRs results monitoring survey to reduce costs, avoid duplications and community fatigue.
- Ensure that the purpose and intent of **each indicator** is clear to reduce the risk of overburdening communities and the CBHW. Consider the amount of staff time to be dedicated to data collection; level of training required; the design of the collection tools (digital or paper-based) and how the data will be utilised.

Data collected by CHW members fall broadly into the following categories, with other CBHW members contributing in specific area:

- Maintaining records on key **demographic information** for each household (e.g., age, gender, pregnancies, births, disabilities) used for day-to-day planning and management of work as well as emergency preparedness and response measures.
- Data linked to **health service access and utilisations** (e.g., register for antenatal/ postnatal care follow-up, immunisation status, place of delivery, non-communicable diseases (NCDs), serious mental health conditions) to monitor uptake of services, trace those lost to follow-up and make referrals.
- **CBS,** including reporting and referral of patients with communicable diseases, alerts for suspected outbreaks, unusual events, deaths (*see **Section 7.6***).
- **Community feedback** including health service satisfaction and complaints as well as rumours and misinformation that may impact health seeking behaviour.
- **Reporting on services provided,** such as health promotion sessions, referrals, maternal/ neonatal home visits or provision of medical care.

It is important to ensure coherence of data collection across levels of care and across partners and sectors, regular data analysis and remedial action as well as feedback to the communities including the CHW and partners on monitoring outcomes, trends and implications.

- Consider how community-based indicators will **link with PHC facility data.** Close collaboration between CHBW team, clinicians, and reporting focal points is crucial to enhance data quality, reporting timeliness and completeness.
- Explore opportunities for **digitization** of data collection, aggregation, and analysis to reduce the workload and improve timeliness of reporting.

© UNHCR/ Yonna Tukundane

- **Disaggregation** of data is an important way to monitor **equity** of programme activities. For example, disaggregation by geographical area can identify particular neighbourhoods, villages or camp blocks that require more focused resources. Disaggregation by age, sex and by refugee or non-refugee status are important to monitor health status across groups and ensure equitable access to health services for all.
- In programmes with staff who are not literate, adapt data collection tools using pictorial aids.
- Supervisors should regularly **monitor the quality of data** collected. This includes ensuring the CHW is correctly collecting and reporting the needed data in a timely manner.
- Ensure **community engagement** in data collection and establish forums to share analysed data back to the CHW and other CBHW members and the community. Consider data display boards in health facilities where key health data from the facility and the community summaries can be accessed easily.
- Have a plan for **data security and maintaining confidentiality** of personal data. This is particularly important for sensitive topics such as HIV and disclosure of GBV.

*See **Annex 3*** for sample data collection forms and registers for CHW and supervisors.

7. Service delivery

Potential areas for community health intervention are broad, and cover aspects of PHC across the lifespan including SRH; maternal, newborn and child health and nutrition; NCDs; communicable diseases and epidemics; MHPSS; and first aid. The foundation of successful interventions, regardless of type, is effective communication and community engagement approaches.

Health services are provided through networks of primary, secondary and tertiary care facilities that can be difficult to navigate, especially in urban areas with complex service provider networks. Linking refugees to health services effectively is a core function across interventions. **Urban programmes** require an especially strong focus on sharing information on service availability, referral procedures and cost. CHBWs tasks may also include accompanying patients to facilities and supporting with translation as well as linking refugees to protection and cash-based intervention programmes where costs are a barrier to access services.

The types of CBHW required, their roles and responsibilities are context-specific and should be defined locally depending on the main health priorities in the refugee population and in line with national approaches, policies and guidelines. For example, low skilled birth attendance or high malaria burden may be public health priorities in some settings but not in others. Likewise, public health priorities - and with it the roles and responsibilities of the CBHW - may change over time according to the phase of the emergency, epidemiology, health facility capacity and other factors. These factors should be considered when reviewing the following list of potential activities.

Programmes should remain a flexible approach to adapt to the disease burden. During communicable disease outbreaks, the focus of the CHW will shift to prioritise outbreak control interventions.

Activities outlined in Section 7 fall predominantly under the responsibility of CHWs unless otherwise indicated.

7.1 Communicable disease control and response

Communicable disease outbreaks present a significant health burden in low resource settings, including in refugee camps. Disease outbreaks including malaria, cholera, measles, COVID-19, hepatitis A and E frequently occur in areas where UNHCR works. In addition, HIV and Tuberculosis (TB) may present a major health burden.

CHWs have demonstrated their capacity to provide a wide range of HIV, TB and malaria services effectively and cost-effectively in the areas of prevention, testing, treatment, and care.[21]

7.1.1 Malaria

Malaria is a major cause of morbidity and mortality globally, including among refugee populations. In 2021, an estimated 247 million cases of malaria occurred worldwide with an estimated 619,000 deaths.[22]

Population movements to areas with higher malaria exposure may result in higher vulnerabilities due to low immunity. Climate change poses a further component expected to impact malaria transmission. Activities for malaria prevention, treatment and control will vary depending on the epidemiological context and national guidelines.

During emergencies, CHW will support malaria control activities with a focus on vector control and enhancing early diagnosis and treatment. In the post emergency phase, malaria control activities will expand to additional preventive approaches and be scaled up in line with national protocols.

Emergency phase	Post-emergency phase (incl. all from emergency phase)
! Provide health information on prevention, signs and symptoms of malaria.	+ Community engagement on indoor residual spraying with emphasis on overcoming potential hesitancies.
! Promote the correct use of insecticide treated nets during distributions and at household level.	+ Promote/distribute seasonal malaria chemoprevention for children 3–59 months, perennial malaria chemoprevention for infants and intermittent preventive treatment of malaria for pregnant women (*where part of national policy*).
! Referral of suspected patients with fever to health facilities with special focus on children under 5 and pregnant women.	+ Promote uptake of malaria vaccines.
! Continue integrated community case management (iCCM) using rapid diagnostic tests where practised by CHWs prior to the emergency, referral of severe cases.	+ Diagnose, treat, and/or refer cases of malaria if iCCM is part of scope of practice.

7.1.2 HIV

Vulnerability to and risk of HIV can increase during humanitarian crises due to reduced access to or lack of HIV prevention, treatment, and support services, along with worsening socio-economic status, particularly for young women, such as loss of livelihoods, and increased risk factors such as sexual exploitation and rape. Additional barriers to testing and treatment often include HIV-related stigma and discrimination, structural barriers for high-risk groups such as adolescent girls/young women and key populations (gay men and other men who have sex with men, individuals engaged in selling or exchanging sex, transgender people and injecting drug users).

In the emergency phase, HIV-related activities should follow the priority objectives of the Minimum Initial Service Package (MISP) (*see **Section 7.2***), with a focus on ensuring community members know where they can access HIV services and continuity of treatment. In post-emergency and protracted settings, decisions on what HIV services to provide at the community level will be informed by local context, resources, and health policy; and whether HIV is considered low-level, concentrated in key populations or generalised. It is also important to understand the community knowledge, attitudes, and perceptions of HIV to combat stigma and to develop relevant and sensitive programmatic approaches. Community-led and community-engaged approaches for HIV can provide safe spaces, advocacy, and alternative approaches to care to overcome barriers and may include actions by CHWs, peer educators and other groups.

Emergency phase	Post-emergency phase (incl. all from emergency phase)
! Provide information on available HIV services. ! Community-based distribution of condoms. ! Link persons on antiretroviral therapy (ART) to health services including pregnant women enrolled in prevention of mother-to-child transmission (PMTCT) of HIV and supporting multi-month drug dispensing according to clinical protocols and medical prescriptions. Identification should be done as part of a broader approach to link persons on chronic medication to services without necessarily enquiring about specific diseases to overcome potential stigma-related hesitancies.	+ SBCC on HIV prevention, signs and symptoms and service access, including tailored approaches for adolescents/ youth and key populations and challenging stigma. + Supporting PMTCT activities including education and referral to testing and adherence to treatment for mother and baby, counselling mothers on infant feeding options and interventions to reduce transmission risks. + Facilitate access to testing including promotion and distribution of HIV self-test kits where part of national policy and after appropriate training; link and accompany people to testing facilities. + Support distribution of ART for those stable on treatment in line with clinical guidance and treatment plans, support ART adherence, trace those lost to follow-up. + Provide psychosocial support to people living with HIV and families. + Engage with key population groups who may not use formal health services on health information, promotion of self-testing, linkage to services and provision of condoms and lubricants. + Facilitate referrals to protection, nutrition, food security including livelihoods, education, or other services as needed. + **HIV peer educators** may in addition facilitate peer support groups, provide practical and emotional support to HIV positive peers; recognise signs of poor coping and refer to professional support; create and maintain safe spaces for people living with HIV to meet.

7.1.3 Tuberculosis (TB)

TB is the leading global cause of death from a single disease agent. TB is often a disease of poverty, affecting people living in overcrowded or unsanitary settings with poor ventilation and/ or poor nutrition. Community-based care for TB has been shown to be acceptable, effective, and cost-effective, when delivered as part of national TB control strategies.

During emergencies, the emphasis is on referring presumptive TB patients for treatment and ensuring continuation of TB treatment and will expand thereafter with an increased focus on health promotion, case identification and treatment adherence.

Emergency phase	Post-emergency phase (incl. all from emergency phase)
Identify patients under treatment and refer to health facilities. This should be done as part of a broader approach to link persons on chronic medication to services without necessarily enquiring about specific diseases to overcome potential stigma-related hesitancies. Refer patients with suspected TB. Support treatment adherence, especially where CHW members have been trained previously, and awareness raising.	Raise awareness on prevention, TB symptoms and increase demand for testing, treatment and support. Identify persons with symptoms, including through active case finding, and link them to treatment. Support people to start, continue and complete TB treatment, including treatment adherence support through community-based directly observed treatment defaulter tracing. Provide psychosocial support for patients and families and support stigma reduction.

7.1.4 Other communicable diseases

In the case of disease outbreaks, CHWs play a role in prevention and health protection; epidemic response; community case management; psychosocial support; CBS; and RCCE. Multi-sectoral collaboration as well as close collaboration with the community and relevant government and civil protection agencies is important for a well-coordinated response. In the post-emergency phase, household visits should take a holistic approach, promoting household hygiene and sanitation, counselling on prevention and identifying, treating, or referring common communicable diseases.

Ensure that the CHW is trained on how to protect themselves against infection and provided with adequate and appropriate protective materials, including PPE, to carry out their duties effectively and safely.

Emergency phase	Post-emergency phase (incl. all from emergency phase)
Provide **key messages** on prevention, signs, and symptoms of priority diseases related to major public health concerns and how to protect oneself. **Hygiene promotion and diarrhoea prevention** including safe drinking water practices, hand hygiene, latrine use and maintenance, food hygiene are core interventions in most situations. Support **mass vaccination campaigns** (e.g., measles, cholera, COVID-19) through information sharing, community mobilisation as well as assisting during vaccination.	Use **holistic approach** to SBCC based on families' individual needs. **Expand and adjust** health promotion to a wider range of communicable diseases depending on the epidemiological situation. Promote **household WASH interventions** including hand hygiene, use of latrines and safe disposal of children's faeces, managing incontinence, safe water storage and usage. **Community case management** (e.g., ORS and zinc treatment at the household) and/ or referral. Operations using an iCCM approach for childhood illnesses will have additional responsibilities (*see* ***Section 7.3***).

Emergency phase	Post-emergency phase (incl. all from emergency phase)
Active case finding and referral, contact tracing during outbreaks and follow-up as well as supporting people who are in self-isolation or quarantine.	Mobilising community leaders and community-led organisations in **epidemic preparedness and response** (*see **Box 5***), including through community taskforces. **Neglected tropical diseases** such as onchocerciasis, leprosy, and lymphatic filariasis may be a priority in some settings, with key CHW actions including health education on symptoms and prevention measures, screening and surveillance or mass chemoprophylaxis according to national control policies and guidelines.

Box 5: COVID-19 and the CBHW

The **COVID-19** pandemic has widely impacted all levels of health service provision globally. Throughout the pandemic the CBHW has played an important role in outbreak prevention and response, including in RCCE, contact tracing, case management, assisting in mass vaccination campaigns, and supporting families in isolation or quarantine. Key resources on how to safely adapt CBHW roles during the pandemic, as well as important areas of community intervention include Community based care in Covid-19 (WHO/ UNICEF/ IFRC) and Communities Getting Involved - Supporting Community Leadership in the Response to the COVID-19 Pandemic (UNHCR, 2020).

7.2 Sexual and Reproductive Health (SRH)

In the context of PHC, SRH includes services such as antenatal, childbirth and postnatal care; contraceptive programmes; prevention and treatment of HIV and sexually transmitted infections (STIs); other pregnancy related care and support; prevention and treatment of cervical cancer (and other reproductive cancers) and prevention and clinical management of sexual violence. Community health activities can increase access to, acceptability of these lifesaving services, keeping in mind the specific needs of adolescents, people who sell or exchange sex, persons with disabilities, persons living with HIV, and persons with diverse sexual orientations and gender identities and expressions.

Emergency phase

In emergencies, the implementation of the Minimum Initial Services Package (MISP) for SRH is a priority. The MISP is a set of priority lifesaving SRH services and activities to be implemented at the onset of every humanitarian emergency to prevent excess SRH-related morbidity and mortality. The MISP objectives (*see **Box 6***) should guide priority actions for CHWs and other CBHWs.

© UNHCR/ Kamrul Hasan

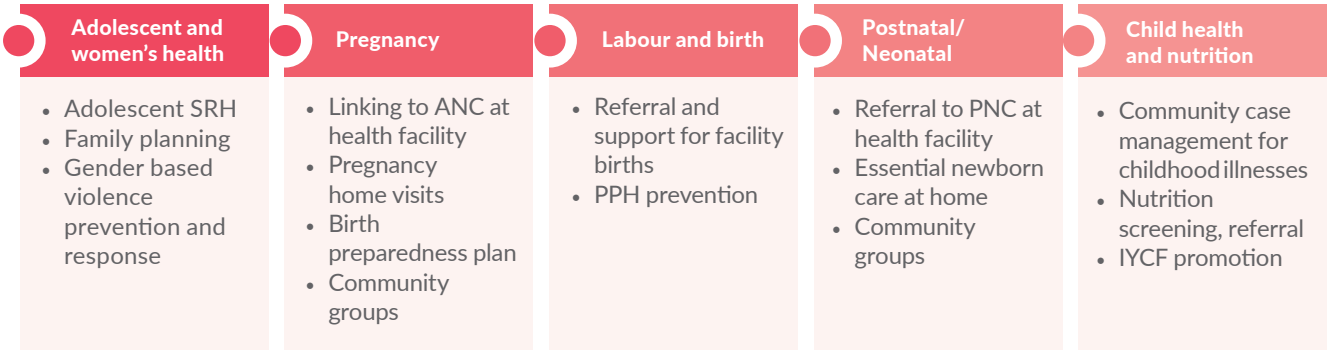
Box 6: MISP objectives

1. Ensure the health sector/ cluster identifies an organisation to lead implementation of the MISP
2. Prevent sexual violence and respond to the needs of survivors
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
4. Prevent excess maternal and newborn morbidity and mortality
5. Prevent unintended pregnancies
6. Plan for comprehensive SRH service as soon as possible

Post-emergency and protracted settings

In post-emergency and protracted settings, a more **comprehensive SRH approach**, strengthening community- and facility-based services should be implemented focusing on a life cycle approach, emphasising integration with national systems (*see **Figure 1***). This may include health promotion, prevention, and curative activities, delivered through home visits, education sessions at health facilities, and group sessions. Activities on menstrual hygiene management (information sharing, distribution of materials) and incontinence (including fistula) should be integrated systematically and be conducted in cooperation with WASH and other sectors. The development of peer educator roles and engagement of TBAs in non-clinical work (*see **Section 3.1***) to complement CHWs roles may be useful in some contexts.

Figure 1: Community interventions in maternal, newborn, child, and adolescent health and nutrition



Adolescent Sexual and Reproductive Health (ASRH)

Adolescents face numerous barriers in accessing SRH services, particularly in humanitarian settings. Health facility services may not be adolescent-friendly, and local health policy and laws may restrict access to services such as contraceptives or safe abortion care. Stigma and restrictive sociocultural beliefs about sexual activity may further restrict access.

Community-based health services as part of an overall ASRH programme have the advantage of engaging this important group through different entry points and approaches (e.g., through school, religious, sports, or social groups; or linked to livelihood initiatives). Note that pregnant adolescents are at higher risk of complications in labour, maternal mortality, low-birth weight/ preterm babies and require additional support on danger sign recognition and birth preparedness planning through formal health providers.

Family planning and contraceptives

CHWs and other community-based cadres (such as community-based distributers and peer educators) can improve knowledge and attitudes towards family planning, increasing contraceptive use, and decrease fertility rates in a cost-effective manner.[23] **Community-based family planning provision** can address geographic, financial, social barriers that may restrict contraceptive use and can bridge the gap between individuals and clinic services.

Pregnancy, childbirth and postnatal/ neonatal care

Maternal and neonatal mortality rates are highest in fragile states and those undergoing a humanitarian crisis. This may be due to poor access to lifesaving services, limited availability of skilled personnel and quality services, and disrupted access to routine and emergency services, particularly during the emergency phase, coupled with other individual, sociocultural and structural barriers. Evidence has shown that **home visits** by CHWs are effective at reducing maternal and neonatal mortality through improving knowledge of essential practices and improving health service utilisation.[24] It is important that men and older family members, as key gatekeepers, are included in all health promotion activities.

TBAs, as respected members of the community, can have an important role in supporting maternal and neonatal health. Women may prefer the care of TBAs due to the culturally appropriate care they provide, particularly in settings where there are barriers to access skilled birth attendants or quality of care in health facilities is perceived as poor. TBAs may be mobilised and re-trained[25] in non-clinical roles to promote the use of skilled birth attendants, seek care for antenatal and postnatal care in health facilities; accompany the woman to the health facility and provide continuous social support during labour in the presence of a skilled birth attendant amongst other health promotion activities.

Box 7: Home visits for the newborn

Three-quarters of neonatal deaths take place during the first week of life and half of these deaths occur at home.[26] Home visits during this critical first week have been shown to reduce neonatal mortality,[27] with home-based care interventions preventing 30-60% of newborn deaths in high mortality settings. In addition to visits during pregnancy, WHO recommends a **schedule of structured home visits** within 24 hours of birth, after 48 to 72 hours, between day 7 and 14 and a 4th visit after 6 weeks, with additional visits for low-birth weight newborns.[28] Key actions include educating families on essential newborn care practices such as early and exclusive breastfeeding; immediate drying, skin-to-skin, and other thermal care; hygiene and cord care practices (including the distribution of chlorhexidine gluconate 7.1% in high maternal mortality settings [>30] where home births are common and harmful substances are provided to the stump **where this is part of national policy**); the importance of immunisation and clinic postnatal visits; and identify and educate on danger signs in the newborn and mother. CHWs can also identify low-birth weight newborns and refer them for extra care, and support kangaroo mother care at home.

In the past few years, UNHCR operations in Jordan, Kenya, South Sudan, Cameroon, Chad and Niger and Bangladesh have implemented structured home visits for the newborn, adapting WHO's Caring for the Newborn at Home package. As part of implementation, partners have established home visit schedules and structured visit content; conducted trainings of CHWs; provided required additional equipment and supplies; and adapted pictorial teaching aids to the local context. In some settings, CHWs also supported the roll-out of kangaroo mother care in health facilities, with CHWs trained to provide additional support to families continuing kangaroo mother care at home.

MISP

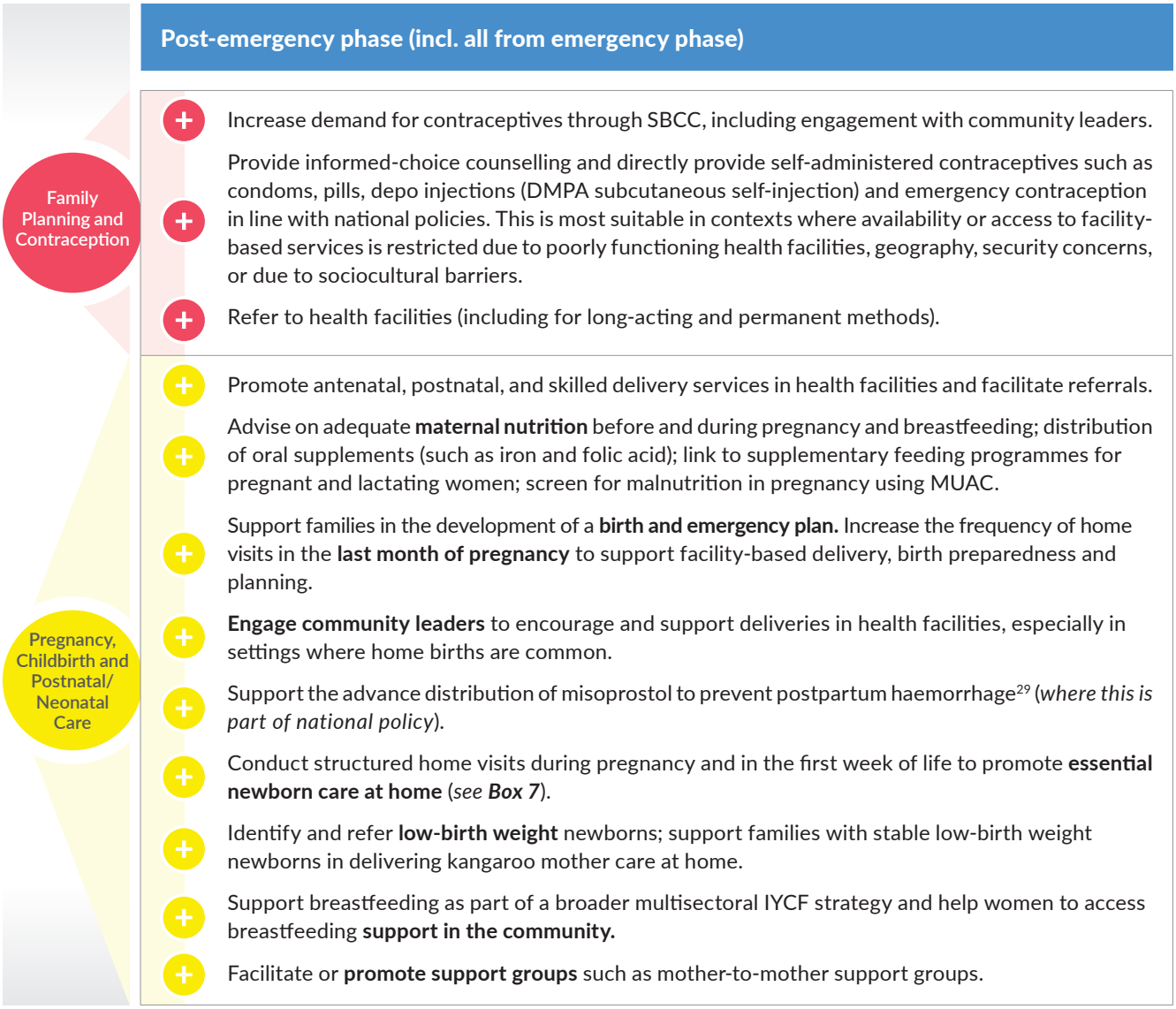
Emergency phase

- Ensure the community is aware of the availability and location of SRH services.
- Support the establishment of a community referral system where this poses a barrier to access health facilities.
- Distribute condoms as well as other short-acting contraceptive methods where already practices before the emergency.
- Support the continuation of treatment for people on ART through community-based distribution to stable patients and adherence support.
- Promote the use of skilled birth attendants, and care seeking, particularly for childbirth, at health facilities.
- Distribute key lifesaving maternal and newborn supplies, including clean delivery kits and essential newborn care supplies, where access to a facility is not possible and in line with national protocols.

ASRH

Post-emergency phase (incl. all from emergency phase)

- Train **CHWs** in ASRH, including on open and non-judgemental attitude, maintaining privacy and confidentiality in their interactions with adolescents.
- Provide age-appropriate targeted information through schools, adolescent-friendly spaces and other venues.
- **Peer educators** may be used to provide information on services and refer; provide counselling or support on key topics (sexuality, contraceptives, HIV and STIs, healthy relationships) and may support the provision of comprehensive sexuality education in schools. Use of peer educators to support adolescents living with HIV is recommended.
- **Coordinate with** and **refer to** protection services, education, psychosocial, and community services for adolescents/ youth, including on prevention of child marriages.



7.3 Child health and nutrition

Children represent a large proportion of refugee populations and children under five are among the most vulnerable groups in humanitarian settings. The leading causes of death for children under five globally are infectious diseases including pneumonia, diarrhoea and malaria, and neonatal causes. Nutrition-related factors underlie about 45% of deaths in this group and high prevalence of acute and chronic malnutrition are of concern in some refugee settings. In older children, accidents and injuries, particularly drowning and road traffic accidents, are leading contributors to mortality and morbidity.[30] Children living in fragile and conflict-affected situations are especially vulnerable with a three-fold higher mortality rate compared to all other countries.[31]

In emergency contexts, initial approaches should be focused on the main causes of morbidity and mortality in children under 5 years (*see* ***Section 7.1***). In the post-emergency phase, household visits should take a holistic approach, promoting adequate nutrition, household sanitation, counselling on prevention, identifying, treating, or referring common childhood illnesses.

Emergency phase	Post-emergency phase (incl. all from emergency phase)
Recognise and counsel parents on illness **danger signs**, promote **timely** care-seeking at health facility.	Promote **routine immunisations,** assist in identifying and mapping zero-dose and under-immunised children, follow-up on immunisation status and trace defaulters.
Advise families where they can seek care for their sick child and refer sick children to health services.	Provide and/ or counsel parents on **home care for illness** (e.g., adherence to treatment, continued feeding, paracetamol and ORS use, danger signs and when to seek care, etc.).
Support mass immunisation campaigns and routine immunisation.	Improve **IYCF** through awareness creation, promotion and support of early initiation and exclusive breastfeeding for the first 6 months, continuation of breastfeeding for at least two years and beyond and counsel families on the age-appropriate introduction of complementary foods.
Promote **exclusive breastfeeding** during the first 6 months of life.	As part of a **community management of acute malnutrition** approach, identify and refer cases of acute malnutrition at the household level and refer to nutrition services; help trace defaulters from nutrition programme and conduct home visit to children who fail to thrive.
Where GAM prevalence is above 10%, prioritise the **identification and referral** of children with acute malnutrition (using MUAC at community level), and **treatment** in coordination with nutrition sector.	**Prevent and treat micronutrient deficiencies** through participation in mass campaigns such as deworming, Vitamin A supplementation, systematic identification and referral of persons with micronutrient deficiency symptoms.
Link **at-risk children** (orphans, unaccompanied children) with child protection services.	Prevent overweight and obesity through **promotion of healthy diet and physical activity.**
Adapt and maintain a community case management approach where previously existing (*see **Box 8***).	

Box 8: Community case management

Community case management involves the diagnosis and treatment or referral of common childhood illnesses by a CHW. **Integrated community case management (iCCM)** of childhood illnesses is a package of care for the assessment and treatment of diarrhoea, pneumonia, and malaria, and assessment and referral for signs of severe illness (dysentery, severe pneumonia and malaria, and acute severe malnutrition) of sick children aged two months up to five years. iCCM is recommended for contexts where there is poor access to, or availability of, primary health facilities. Given the diagnostic and curative components of iCCM, it is important to ensure a strong supply chain, supportive supervision, training and mentoring from health providers. Previously established iCCM programmes should be maintained and/ or adapted during humanitarian crises.

7.4 Non-communicable Diseases (NCDs)

NCDs are the leading cause of death and disability worldwide, with 77% of all NCD deaths occurring in low- and middle-income countries. Cardiovascular diseases, cancer, respiratory diseases, and diabetes account for over 80% of all premature NCD deaths.[32]

Many low- and middle-income countries face a **double burden** of both communicable and NCDs, with protracted crises increasing the need for integrated NCD care in refugee operations.

Box 9: Priority NCDs in refugee influxes

- Cardiovascular diseases (including heart failure, coronary heart disease and stroke)
- Hypertension
- Asthma and chronic obstructive pulmonary disease
- Diabetes mellitus

In a refugee influx, community health-related priorities for NCDs should be focused on supporting the continuum of care for those on medication as well as referral for acute management of **priority conditions**, particularly those who require lifesaving and acute care. In the **context of communicable disease outbreaks** which may result in movement restrictions (e.g., **COVID-19**), CHWs play a key role in community engagement, including providing targeted support to high-risk populations such as patients with NCDs by promoting preventative measures and helping to deliver medications to at-risk patients.

In post-emergency and protracted settings, CHW will increasingly focus on *prevention of NCDs* throughout the lifespan, particularly as it relates to promoting and supporting healthy nutrition, physical activity, and reducing harmful alcohol, tobacco, and drug use. Health promotion messaging must be adapted to the local context, keeping in mind that NCD management at the primary care level may be limited, food choices may be limited and opportunities for physical exercise may also be impacted due to security concerns or the cultural limitations to exercising outdoors, especially for women.

Emergency phase	Post-emergency phase (incl. all from emergency phase)
! Support the continuum of care for those on medication by providing information on available services and referral.	+ Liaise between clinical staff and people living with NCDs and strengthening continuity of care through follow-up of patients in the community.
! Referral to health facilities for acute management of **priority conditions** (*see **Box 9***), particularly those who require lifesaving and acute care.	+ Monitoring progress of patients including blood sugar and blood pressure, treatment adherence and onset of complications during home visits.
! Support medication refills for patients with stable conditions.	+ Increase community awareness on prevention, signs and symptoms and care of priority NCDs.
! Identify and refer community members with chronic conditions or disabilities that require additional support from protection, shelter, WASH or other services.	+ Use mHealth approaches for reminders on appointments and health messaging.
	+ Promote healthy nutrition, physical activity and reducing intake of harmful substances.

© UNHCR/ Will Swanson

7.5 Mental Health and Psychosocial Support (MHPSS)

The term 'mental health and psychosocial support' refers to any type of support that aims to protect or promote psychosocial well-being or prevent or treat mental health conditions. This includes interpersonal problems, emotional distress, common mental conditions (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and other substance abuse, epilepsy and intellectual disabilities. Displaced communities, particularly those who have fled conflict situations, have an increased prevalence of mental health and psychosocial problems due to adverse experiences and losses during the displacement, economic difficulties, disruption of supportive social systems, and worries for the future.

UNHCR promotes an integrated 'MHPSS approach' – considering MHPSS actions in all sectors and activities. At the community level MHPSS activities are closely aligned with both health and community-based protection and therefore activities of community outreach workers from these sectors must be closely coordinated. *See **Box 10*** for further information on when to consider a separate MHPSS worker role.

Emergency phase

During an emergency, MHPSS-related work of CHWs may include focuses on Psychological First Aid and linking people to services. In **post-emergency and protracted phases**, MHPSS-related actions should focus on community empowerment, building self-reliance, strengthening linkages to surrounding systems of care in the community and helping to maintain or revitalise positive support systems or strategies that refugee populations used before displacement.

Emergency phase	Post-emergency phase (incl. all from emergency phase)
! Identify, safely refer, and assist people in emotional distress or demonstrating challenging behaviour. ! Provide GBV survivors with survivor-centred information (where to obtain response services and what to expect) and referral. ! Facilitate referrals between health and protection/ community services. ! During communicable disease outbreak (e.g., COVID-19, Ebola), provide disease specific information on stress management and healthy coping styles. ! Provide Psychological First Aid.	+ Identify people with moderate and severe mental health conditions and epilepsy, particularly the most vulnerable among them, and link them to health facilities and other available services. + Identify people with common mental health conditions (such as depression and posttraumatic stress disorder) and link them to providers of psychological interventions.[33] + Follow-up and support those with a diagnosed mental health condition at home (medication adherence; enable supportive home environment). + Raise awareness in the community about mental health conditions, substance use and epilepsy and provide information about when and where to seek help. + Support and refer to community-based programmes for reducing harmful alcohol or drug use.

Box 10: When to consider a separate MHPSS worker role

While all community outreach workers, including CHWs, should receive training on the basics of MHPSS (such as Psychological First Aid), in some settings a separate MHPSS worker may be considered. A MHPSS worker will have more knowledge and, in addition to the interventions listed above, may provide brief psychological interventions after being trained, facilitate support groups for specific patient groups and provide additional support to people who are grieving, under the clinical supervision of a mental health professional. This specialised role may be considered when:

- Large target population (>50,000) in camps with well-developed mental health activities integrated within general health facilities, with clinicians (such as psychiatric nurses) available for training and clinical supervision, **OR**
- Hard to reach urban populations with significant protection concerns (e.g., LGBTIQ+, trafficked people), **OR**
- A stand-alone partner for MHPSS is present with sufficient financial and human resources to train and supervise the MHPSS workers with a functioning referral system to higher level care.

7.6 Community-based Surveillance (CBS)

Community-based surveillance is '*the systematic detection and reporting of events of public health significance within a community, by community members*'.[34] CBS systems should be integrated into a formal surveillance structure, be actionable and timely, and have well-defined reporting and feedback mechanisms.

There is currently limited standardisation of CBS with different implementation practices across countries. CBS generally includes reporting on epidemic-prone and/ or notifiable diseases, community-based mortalities, rumours and unusual events (*see **Box 11***). **CBS focal points** in the community can be any acceptable community member (including CHWs, community leaders, TBAs, etc.), however CHWs are often responsible for this task. The CBS catchment area should be linked to a primary healthcare facility, data collection and analysis should be part of a wider health surveillance and monitoring approach closely coordinated with relevant government structures and systems, feeding into iRHIS, community health information systems and an EWARS if existing.

Box 11: Priority diseases to include in CBS will be determined locally, but should meet the following criteria[35]

- Have the potential for high public health impact (e.g., high case fatality rates, high incidence or prevalence, degree of infectiousness), **AND**
- Effective interventions exist to interrupt transmission quickly and early, **AND**
- It is feasible for the CBS focal point to identify the suspected condition based on standard (simplified) community case definitions.

Key responsibilities of a CBS focal point (CHW or other) include:[36]

- ✔ Collect data, refer patients and send timely notification of the occurrence of unexpected or unusual cases of disease or death.
- ✔ Report community-based mortalities and participate in community cause-of-death interviews and verbal audits to determine suspected causes of death (where appropriate).
- ✔ Involve local leaders in describing disease events and trends in the community.
- ✔ Support health workers during outbreak investigation and contact tracing.
- ✔ Participate in risk mapping of potential hazards and in training including simulation exercises.
- ✔ Participate in response activities including community or home-based care, RCCE during outbreak.
- ✔ Provide feedback to the community on outbreak/ event assessment.

Mortality surveillance and response

As part of community-based surveillance, mortality data collection provides a critical indicator related to the overall health of a population, and can help estimate the severity of a crisis, the effectiveness of the response and, ideally, contribute to preventing similar deaths in the future. This is particularly important where a large proportion of deaths occur outside of a health facility.

Key actions related to community-based mortality surveillance include:

- Community mobilisation and engagement to ensure the community understands the importance of sharing mortality information and helps to establish locally appropriate reporting and communication channels.
- Community leaders, religious leaders, CHWs, graveyard or cremation ground managers and other relevant stakeholders should be mobilised to maximise the identification of community-based deaths.

- Community-based mortality surveillance data should be triangulated with facility-based sources and included in the central mortality register.
- CHW supervisors and/ or clinical staff should regularly follow-up mortality cases, particularly in geographic areas that are reporting unusually high or low mortality rates.

Maternal and neonatal deaths require additional attention. Under the leadership of primary healthcare facility and designated authorities, community-based maternal and neonatal deaths may be investigated using verbal audits approach or community cause of death interview of family members or others in the community who looked after the deceased at or near the time of death. Community participation can provide more accurate information on the number of deaths, where they occurred, and some of the contributing factors to the deaths. *See **Annex 2*** for sample mortality reporting forms and registers.

7.7 Community-based first aid

First aid is the immediate assistance provided to an ill or injured person until professional help can be accessed. It includes management of physical illness or injury as well as the initial psychosocial support for people who are emotionally distressed. The CHWs (or other trained community members) role in first aid may include:

Emergency phase	Post-emergency phase (incl. all from emergency phase)
! Following training, **provide basic first aid** using a structured approach to the injured including basic care for burns, bleeding and wounds, choking, and basic life support. ! Provide information on emergency services and emergency transport plans. ! Help arrange **emergency transport** and accompany patient to the health facility. ! Provide Psychological First Aid (*see **Section 7.5***).	+ Assist community in developing an emergency response plan including transport and communication. + Provide family and community education on **prevention:** preparedness for emergencies and accidents; access to emergency services and emergency transport plans; awareness of **context-specific risks and hazards** such as unstable infrastructure or risk of injury during rescue attempts; landmines; fire risks; drownings, etc.

Annexes and references

Annex 1

Inter-sectoral integration of community outreach roles

Nutrition

Context	Tasks of nutrition outreach worker	Tasks of CHW
GAM > 10%	• Home visits including MUAC screening, IYCF promotion • Linking children under 5, pregnant and lactating women to nutrition programmes • Home visit to follow-up malnourished children who don't thrive, defaulter tracing • Small group/ community meetings on nutrition topics, including specialised group activities e.g., mother support groups • Support mass campaigns (mass MUAC screening, deworming, vitamin A) • Training and follow-up of mothers on the family lead MUAC	• Home visits - Promotion of early initiation and exclusive breast feeding as part of SRH activities - Referral of children and pregnant/ lactating women who are not enrolled in nutrition programmes • CHWs can cover activities outlined for the nutrition outreach worker as an alternative strategy. Adjustments to the CHW ratio will need to be considered to account for the increased workload
GAM < 10%	• Specialised group activities e.g., mother support groups • Home visit to follow-up malnourished children who don't thrive	• Home visits taking a holistic approach addressing health, hygiene and nutrition and provide targeted messages based on assessment including: - Nutrition information, education and communication and awareness on available services, including referral to appropriate nutrition programmes - IYCF counselling and promotion, MUAC screening and referral - Defaulter tracing - Home visit to follow-up malnourished children who don't thrive (where there is no nutrition worker) - Small group/ community meetings on nutrition topics and breastfeeding support - Support mass campaigns (mass MUAC screening, deworming, vitamin A) and growth monitoring

WASH

Context	Tasks of WASH outreach worker/ hygiene promoter	Tasks of CHW
New emergencies		• Home visits - Key messages on hygiene promotion, diarrhoea prevention - Case management (e.g., providing ORS); referral to health facilities • Community-based surveillance
Communicable disease outbreaks *(e.g., cholera)*	• Household follow-up – messaging jointly with CHWs, focus on disinfection/ water safety • Community mobilisation in enhancing accessibility and use of WASH facilities - Design and promotion of usage of latrines - Establishment and functioning of water committees - Water point management including functionality	• Home visits - Hygiene promotion - Disease specific information on prevention and treatment - Community case management (e.g., providing ORS, zinc) or referral of suspected cases • Specialised activities - Patient/ household follow-up, messaging, and community case management, identifying other potential patients, contact tracing - Health/ hygiene promotion through other media/ channels community leaders, radio, SMS, posters, megaphones, theatre) - Support to mass vaccination campaigns - Management of community ORS points • Community-based surveillance
Stable situation	**Tasks of WASH outreach worker/ hygiene promoter**	**WASH tasks: Integrated CHW role**
	• Specialised tasks: - Community engagement/ mobilisation in WASH facility design and construction - Water committee establishment and engagement - Hardware and water point management	• Home visits taking a holistic approach addressing health, hygiene and nutrition and provide targeted messages based on assessment - Monitoring hygiene/ WASH situation at HH level - Behaviour change communication at HH level, hygiene promotion, diarrhoea prevention messaging - Community case management of illness (e.g., ORS provision) • Community-based surveillance

MHPSS

Context	Tasks of MHPSS outreach worker	Tasks of CHW
New emergencies	• Provision of psychological first aid (PFA) to people in severe distress and refer those in need of additional support • Provide key messages on healthy coping styles and stress management	• Provision of psychological first aid (PFA) to people in severe distress and refer those in need of additional support • Identify and refer people with severe and acute mental health risks or conditions during home visits
Stable situation	**MHPSS worker**	**MHPSS tasks: INTEGRATED CHW role**
	• Brief psychological interventions (***see Annex B*** Global Public Health Strategy 2021-2025) • Supportive psychosocial interventions (individual or in groups) • Help communities re-establish social support systems that existed prior to displacement • Facilitate support groups for mental health conditions and for those with problematic alcohol or drug use; develop suicide prevention programmes • Provide targeted support to people with severe mental health conditions and their families	• Home visits taking a holistic approach addressing health, hygiene and nutrition and provide targeted messages based on assessment • Provide key messages on healthy coping styles • Identify, follow-up and support those with mental health conditions at home (medication adherence; check for supportive home environment) in the absence of MHPSS worker)

Annex 2

Sample ToR community health worker

Objective

Engage and communicate with individuals, families and communities to foster well-being, health and health seeking behavior, and link community members effectively to health facilities through promotive and preventive health outreach activities.

Detailed list of activities:

- Engage with individuals and families at household level to understand their needs and capacities with regards to health, nutrition and hygiene practices and behaviours.
- Engage with community leaders (religious leaders, refugee leaders, teachers etc) and conduct small group sessions with communities on health, hygiene and nutrition topics.
- Conduct health and hygiene promotion, communicate on disease prevention and healthy living and link refugees to health facilities:
  - Communicable diseases (e.g., malaria, diarrhea, respiratory tract infections, HIV, STI, TB, etc.) and non-communicable diseases.
  - Promote vector control activities, e.g., insecticide treated net usage, clean home environment.
  - Promote routine immunisation and mobilise for mass vaccination campaigns.
  - Hygiene promotion, including food hygiene and diarrhea prevention. Promotion of safe sanitation, household waste management and appropriate water treatment and storage.
  - Identify, follow-up and support persons with mental health conditions at home (medication adherence, supportive home environment).
  - Help in identification and addressing practices which are harmful to the health of the individual and the community.
  - Raise awareness, counsel and promote usage of facility-based SRH services:
    - *Communicate on and referral to antenatal care, postnatal care, family planning, safe delivery at health facilities.*
    - *Support the development of birth preparedness plans and facilitate transfer for delivery in health facilities.*
    - *Condom distribution.*
    - *Conduct community level postnatal and neonatal home care visits, follow-up on newborn health, identify danger signs and refer for proper care.*
  - Nutrition related tasks:
    - Promote appropriate infant and young child feeding practices (IYCF) and healthy nutrition during pregnancy and lactation.
    - Conduct MUAC screening and referral, link pregnant and lactating women and children under 5 to appropriate nutrition programmes.
- Share information on available health services and referral pathways (including nearest 24/7 health facility). Support community referral of refugees in need of health care services by liaising with health facilities, porters and stretcher services available.

- Support individuals and families for scheduled follow-up visits and conduct defaulter tracing (e.g., EPI, TB, NCD, nutrition programme).
- Conduct community-based surveillance for notifiable diseases and unusual events, rumors and community-based mortalities and births.
- Maintain records of key information on household health and demographic data (age, gender, EPI, ANC, etc.).
- Liaise with other workers including e.g., nutrition workers, community psychosocial workers, protection workers to ensure referrals to other services are smoothly performed.
- Provide first aid and psychological first aid in line with training received .

Personal requirements

Essential:

- ✔ Living within the camps/ areas of their deployment
- ✔ Able to speak the same language as the refugees
- ✔ Good communication and social skills
- ✔ Willing to participate in initial and ongoing trainings
- ✔ At least 6-month commitment

Desirable attributes:

- ✔ Previous working experience as CHW or in a similar function.
- ✔ Completed 8th grade
- ✔ Ability to read and write

Annex 3

Sample SOP for CHWs and sample forms

Guidance Note for Community Health Worker/ Volunteer, Bangladesh Rohingya Response. 2018

Sample Forms (see the Public Health Section Community of Practice to download):

- Sample registers
  - Household demography register
  - ANC/ PNC/ Newborn visits register
  - Immunisation register
  - Rumours register
  - Unusual event register
- Reporting forms: Live birth, mortality, unusual event, referral forms
- Supervisor reporting form

Annex 4

Additional resources

Global Policies, guidelines and strategies

- UNHCR Global Public Health Strategy (2021 - 2025)
- WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (2018)
- Care in Communities: Guidelines for National Red Cross Red Crescent Societies - A Community Health Systems Approach (2020)

Monitoring and evaluation

- UNHCR's Integrated Refugee Health Information System (iRHIS)
- DHIS2 Community Health Information System Guidelines
- Minimum Quality Standards and Indicators in Community Engagement (UNICEF, 2020)
- Analysis and use of community-based health service data: Guidance for Community Health Worker Strategic Information and Service Monitoring (UNICEF, 2021)

Community-based and participatory approaches

- UNHCR A Community Based Approach Manual (2006)
- WHO Recommendation on Community Mobilization through Facilitated Participatory Learning and Action Cycles with Women's Groups for Maternal and Newborn Health (2014)
- SBCC for Emergency Preparedness Implementation Kit (Johns Hopkins, 2020)
- Communicating risk in public health emergencies: A WHO Guideline for Emergency Risk Communication (ERC) Policy and Practice. (WHO, 2017)

Communicable disease control

- WHO: Health Policy and System Support to Optimize CHW Programmes for HIV, TB and Malaria Services: an Evidence Guide (WHO, 2021)
- Guidance Note on Malaria Programmes in Refugee Settings (UNHCR 2022)
- Optimizing Community Health Worker Programmes for HIV Services (WHO, 2021)
- Children, Adolescents & HIV: A Simple Toolkit for Community Health Workers and Peer Supporters (PATA, 2015)
- Tuberculosis Prevention and Care Among Refugees and Other Populations in Humanitarian Settings (WHO, UNHCR, CDC 2022)
- Epidemic Control for Volunteers: ECV Training Manual; ECV Toolkit (IFRC, 2020)
- Community Based Care in Covid-19 (WHO/ UNICEF/ IFRC)

Sexual and reproductive health and rights

- UNHCR. Adolescent Sexual and Reproductive Health in Refugee Situations: A practical Guide to Launching Interventions in Public Health Programmes. (2019)
- UNHCR Operational Guidelines for Maternal and Newborn Health in Refugee Settings
- ASRH Toolkit for Humanitarian Settings : 2020 Edition (IAWG)
- The Inter-agency Working Group on Reproductive Health in Crisis Field Manual (2018)

- Engaging Men in Sexual and Reproductive Health and Rights Including Family Planning
- High Impact Practice: Community Health Workers: Bringing Family Planning Services to where People Live and Work (Johns Hopkins University, 2022).
- Newborn Health in Humanitarian Settings Field Guide (Save the Children, UNICEF, 2018)
- Caring for the Newborn at Home training course (WHO)

Child health and nutrition

- Infant and Young Child Feeding in Refugee Situations: A Multi-Sectoral Framework for Action (UNHCR/ Save the Children 2018)
- Home Visits for the Newborn Child: a Strategy to Improve Survival: WHO/ UNICEF Joint Statement. (WHO, 2009)
- Caring for the Sick Child in the Community Training Course (WHO)
- Caring for the Sick Child in the Community, Adaptation for High HIV or TB Settings
- Community Case Management (CCM) in Humanitarian Settings: Guidelines for Humanitarian Workers. (Save the Children, 2019)

Non-communicable diseases

- Integrating Non-communicable Disease Care in Humanitarian Settings. (UNHCR and IRC 2020)
- Package of Essential Non-communicable Disease Interventions for Humanitarian Settings (PEN-H). (IRC and USAID 2020)

Community based surveillance

- Integrated Disease Surveillance and Response in the African Region: A Guide for Establishing Community-based Surveillance. (WHO, 2014).
- Community-based Surveillance: Protocol Template (IFRC, 2019).
- UNHCR Guidelines for Mortality Surveillance: A Practical Guide for Collecting, Reporting, and Using Surveillance Data for Estimating Mortality in Refugee Settings (UNHCR, CDC, 2023, forthcoming)

MHPSS

- Strengthening Mental Health and Psychosocial Support in 2021 (UNHCR,2021)
- Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations (UNHCR 2013)
- Basic Psychosocial Skills: A guide for COVID-19 Responders (IASC, 2020)
- Mental Health and Psychosocial Support Annex B in Global Strategy for Public Health 2021-2025 (UNHCR, 2021)
- United Nations High Commissioner for Refugees (2022). Planning for Prevention and Risk Mitigation of Suicide in Refugee Settings. A toolkit for multisectoral action. Field-test version 2022. Geneva, Switzerland

Training, online courses and other digital resources:

- An Introduction to Public Health in Refugee Settings
- Covid-19 Digital Classroom (numerous languages) (Community Health Academy)
- The Community Health Academy app
- Strengthening Community Health Worker Programs Course (HarvardX)
- Community Engagement Course Series
- Community-based Health and First Aid: Training Guides and Tools (IFRC)
- Medical Aid Films (short clips for CHWs on various health topics)
- Community Health Toolkit (open-source community health app)

References

1. WHO guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.
2. Trained community health worker titles vary widely from country to country (e.g., village health worker, community health and nutrition volunteer, community health aide, community health promoter, health extension worker, lay health advisor, lady health visitor). For simplicity and consistency, the term Community Health Worker (CHW) is used throughout this document.
3. Finance Alliance for Health. Strengthening Primary Health Care through Community Health Workers: July 2015 Investment Case and Financing Recommendations https://www.who.int/hrh/news/2015/CHW-Financing-FINAL-July-15-2015.pdf.
4. Community Health Roadmap. Summary of the methodology used to estimate the potential impact on lives saved of fully optimized community health platforms in 15 countries of the roadmap. https://www.communityhealthroadmap.org/methodology.
5. Miller, N, Ardestani, F, Dini, H. et al. Community health workers in humanitarian settings: Scoping review. Journal of Global Health (2020) 10:2 doi: 10.7189/jogh.10.020602.
6. Scott, K., Beckham, S., Gross, M. et al. What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. Human Resources for Health (2018) 16:39 https://doi.org/10.1186/s12960-018-0304-x.
7. UNICEF. 2020. Minimum quality standards and indicators in community engagement: A guidance towards high quality, evidence-based community engagement in development and humanitarian contexts. https://www.unicef.org/mena/reports/community-engagement-standards.
8. SBCC for Emergency Preparedness: Implementation kit. USAID. 2020 https://sbccimplementationkits.org/sbcc-in-emergencies/learn-about-sbcc-and-emergencies/what-is-social-and-behavior-change-communication/.
9. WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health. WHO. 2014. https://apps.who.int/iris/bitstream/handle/10665/127939/9789241507271_eng.pdf.
10. Prost, A. et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. The Lancet, Volume 381, Issue 9879, 1736 – 1746.
11. Miller NP, Milsom P, Johnson G, Bedford J, Kapeu AS, Diallo AO, et al. Community health workers during the Ebola outbreak in Guinea, Liberia, and Sierra Leone. Journal of Global Health. 2018;8
12. Kozuki N, Ericson K, Marron B, Lainez YB, Miller NP. The resilience of integrated community case management in acute emergency: a case study from Unity State, South Sudan. Journal of Global Health. 2018;8:020602.
13. Shah R. Community case management during flooding emergencies in southern Bangladesh: A case study. Save the Children, 2018.
14. WHO guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.
15. United Nations High Commissioner for Refugees. Adolescent sexual and reproductive health in refugee situations: A practical guide to launching interventions in public health programmes. 2019 Edition. https://www.unhcr.org/protection/health/5d52bcbd4/adolescent-sexual-reproductive-health-refugee-situations-practical-guide.html.
16. WHO guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.
17. Finance Alliance for Health. Strengthening Primary Health Care through Community Health Workers: July 2015 Investment Case and Financing Recommendations https://www.who.int/hrh/news/2015/CHW-Financing-FINAL-July-15-2015.pdf.

18. Performance-based incentives refer to the provision of financial or non-financial rewards based on achievement of a predetermined performance target. Targets may include health outcomes, delivery of interventions (e.g., number of home visits done, number of referrals to health facility by TBAs), rates of service utilisation, or quality of care.
19. Naimoli, J.F., Perry, H.B., Townsend, J.W. et al. Strategic partnering to improve community health worker programming and performance: features of a community-health system integrated approach. Hum Resour Health 13, 46 (2015). https://doi.org/10.1186/s12960-015-0041-3.
20. UNHCR. Guideline for Rehabilitation and Assistive Technology. 2023 (forthcoming).
21. Health policy and system support to optimize community health worker programmes for HIV, TB and malaria services: an evidence guide. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.
22. WHO World Malaria Report 2022. 8 December 2022. Global report. https://www.who.int/publications/i/item/9789240064898.
23. Community Health Workers: Bringing family planning services to where people live and work. Johns Hopkins 2022. https://www.fphighimpactpractices.org/briefs/community-health-workers/.
24. Gogia, S., Sachdev, H. Home-based neonatal care by community health workers for preventing mortality in neonates in low- and middle-income countries: a systematic review. J Perinatol 36, S55–S73 (2016). https://doi.org/10.1038/jp.2016.33.
25. Where TBAs are engaged in programmes, an explicit reference that the TBA will not conduct deliveries may be helpful as part of a working contract/ agreement.
26. World Health Organization. (2009). Home visits for the newborn child: a strategy to improve survival: WHO/UNICEF joint statement. https://apps.who.int/iris/handle/10665/70002.
27. Tiruneh, G.T., Shiferaw, C.B. & Worku, A. Effectiveness and cost-effectiveness of home-based postpartum care on neonatal mortality and exclusive breastfeeding practice in low-and-middle-income countries: a systematic review and meta-analysis. BMC Pregnancy Childbirth 19, 507 (2019). https://doi.org/10.1186/s12884-019-2651-6.
28. World Health Organization. (2022). WHO recommendations on maternal and newborn care for a positive postnatal experience https://www.who.int/publications/i/item/9789240044074.
29. WHO recommendation on advance misoprostol distribution to pregnant women for prevention of postpartum haemorrhage. Geneva: World Health Organization; 2020.
30. World Health Organization. Children: Improving survival and well-being. 8 September 2020. https://www.who.int/news-room/fact-sheets/detail/children-reducing-mortality.
31. UN Interagency Group for Child Mortality Estimation (UN IGME). Levels and trends in child mortality: Report 2021. https://data.unicef.org/resources/levels-and-trends-in-child-mortality/.
32. Noncommunicable diseases fact sheet. WHO. 13 April 2021. Available from https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.
33. Scalable psychological interventions are brief therapies that can be provided by trained and supervised non-specialists. Examples are Problem Management Plus (PM+), Interpersonal Therapy (IPT), Self Help Plus or Integrative Adapt Therapy (IAT). See the table on page 46/47 of the Public Health Strategy 2021-2025 (https://www.unhcr.org/6253f6aa4).
34. Technical Contributors to the June 2018 WHO meeting. A definition for community-based surveillance and a way forward: results of the WHO global technical meeting, France, 26 to 28 June 2018. Euro Surveill. 2019;24(2):pii=1800681. https://doi.org/10.2807/1560-7917.ES.2019.24.2.1800681.
35. IFRC. Community-based surveillance: protocol template. International Federation of Red Cross and Red Crescent Societies, Geneva. 2019. https://oldmedia.ifrc.org/ifrc/wp-content/uploads/2020/02/IFRC_CBS_Protocol_EN_2019_Web.pdf.
36. WHO. Integrated disease surveillance and response in the African Region: a guide for establishing community-based surveillance. 2014. World Health Organization. Regional Office for Africa.

OPERATIONAL GUIDANCE:

Community Health in Refugee Settings