



Is there a role for Community Health Workers in adolescent health services?

Introduction

Adolescent health is increasingly seen as an important international priority - 1.8 billion young people aged 10-24 account for 15.5% of the global burden of disease, and an estimated 70% of premature adult deaths are attributed to unhealthy behaviours often initiated in adolescence, such as smoking, obesity and physical inactivity.

WHO proposed a package of health services to address the needs of youth aged 10-24 years. Known as the Youth Friendly Health Services (YFHS) programme, it addresses complex issues such as substance abuse, obesity and violence, and sexual and reproductive health services.

While criticised by some for poor coverage and inadequate implementation, there have been calls for YFHS to be scaled up as an innovative health service delivery model. However, evidence of increasing utilisation of YFHS in low and middle income countries reflects a lack of data on process evaluations, long-term follow up, cost effectiveness and the impact on health outcomes.

In South Africa, despite reported implementation of a Youth Friendly Services (YFS) at nearly half the country's primary health facilities, early evidence from a rural Mpumalanga case study indicates human resource, infrastructure and management shortcomings and much room for improvement.

More research is required on whether these challenges are an accurate reflection of the national YFS delivery model, and to determine effective modes of adolescent health service delivery.

Conclusions and recommendations

- There is limited evidence on the impact of YFHS in sub-Saharan Africa. More research is required to validate whether YFHS can be delivered effectively through innovative service delivery programmes such as those potentially offered through CHW programmes.
- The research did not find any study which examined the comparative effectiveness between generalist and specialist CHWs. Rigorous studies are needed to establish this. In South Africa, it is unclear which approach is preferable. Process evaluations are needed, as well as economic data to demonstrate cost-effectiveness.
- Adequate supervisory structures should be in place to provide generalist and specialist CHWs with support and acceptance as formal members of the health workforce.
- Decision-makers should partner with research institutions and practitioners to formulate a research agenda and ensure that evidence on CHWs and YFHS are incorporated into policy.

Community Health Workers (CHWs) have potential for strengthening delivery: they are often part of well-established primary health care programmes, would not require advanced training, and typically engage target populations at grassroots levels in ways that facilitate the uptake of healthy behaviours.

However, the CHW approach has been criticised for fragmented delivery, inadequate supervision, inconsistent training, resource shortages and political controversy.

This research sought to determine if there was evidence to support the delivery of adolescent health services through CHWs in sub-Saharan Africa, and whether a 'generalist' or 'specialist' approach was optimal.

Methods

This was a systematic review of original English language research articles from 1950 to October 2012 on CHW programmes in sub-Saharan Africa, using PubMed-Medline, EBSCO, Global Health and Global Health Archive and five CHW reviews. A CHW was defined as a lay individual responsible for providing various health services at the community level. A 'generalist' CHW had a broad mandate and 6 months' initial training who attempted to serve the primary healthcare (PHC) needs of the whole community, while a 'specialist' CHW had a narrowly defined set of skills determined by population group (e.g. adolescent health) or disease (e.g. tuberculosis) with two-weeks' training.

Results

The researchers found 106 articles from 24 African countries. Figure 1 illustrates the most common types of studies; Figure 2 indicates the best represented countries.

Most common types of studies

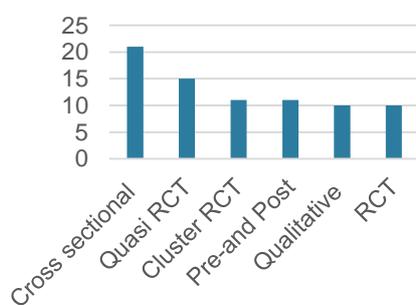


Figure 1

Most articles by country

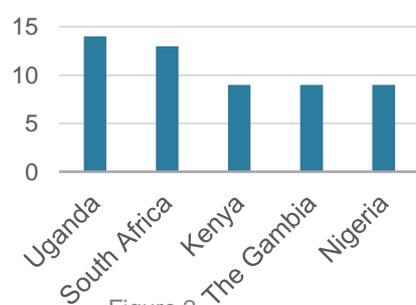


Figure 2

There was only one article which matched the search criteria of CHWs delivering adolescent health services which delivered promising results. However, it was unclear to what extent its success could be attributable to CHWs since it also included community activities, school-based sexual health education and peer condom social marketing. While both generalist and specialist CHWs could be suitable for facilitating the uptake of adolescent health messages, the review found insufficient evidence to support one approach over the other.

South Africa is now integrating its CHW programmes into municipal ward-based outreach teams of about five 'generalist' CHWs with a broad range of responsibilities. This approach allows for the diverse skills of formerly fragmented CHW programmes to be utilised more systematically, but does not preclude the possibility of integrating specialist CHWs.

In the absence of evidence on the comparative advantages of both models, selected advantages and limitations are provided in the table below.

This policy brief was based on two articles: "[A review of generalist and specialist community health workers for delivering adolescent health services in sub-Saharan Africa](#)", *Human Resources for Health*, 2013, 11:54 and "[Considerations for linking South Africa's youth-friendly services to its community health worker programme](#)", *A Journal of Child Health*, 2014; 8(3): 85-87.

References available on request.

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Generalist approach		Specialist Approach	
Advantages	Limitations	Advantages	Limitations
Linking YFS to existing CHW programmes could be quicker and more affordable	CHWs (mainly older women) may have difficulties gaining trust of young people	Recruitment of youth is more likely to lead to trusting peers more easily	Adolescents have networks of friends, family and neighbours and adolescent health cannot operate in a vacuum
Adding adolescent health to existing CHW training minimises disruptions to protocols	CHWs are overburdened. Extra responsibilities without compensation may affect quality, motivation and retention	Exclusive targeting of households with adolescents could lead to more households visited	Unclear if a specialist CHW would add or limit stigma of home visits
May be politically easier to sustain rather than setting up (overlapping) cohort of workers	Additional skills may aggravate gaps in supervision	Rapid acquisition of expertise in YFS skills and professional relationships could lead to quicker results by linking facility and household services	A specialised workforce will require massive supervision and could be costly, difficult to implement and politically challenging to sustain