Sexual and reproductive health
Core competencies in primary care

ATTITUDES · KNOWLEDGE · ETHICS · HUMAN RIGHTS

LEADERSHIP · MANAGEMENT · TEAMWORK

COMMUNITY WORK · EDUCATION · COUNSELLING

CLINICAL SETTINGS · SERVICE · PROVISION

World Health Organization

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WHO

For more information, please contact:

Department of Reproductive Health and Research
World Health Organization
Avenue Appia 20, CH-1211 Geneva 27, Switzerland
Fax: +41 22 791 4171
E-mail: reproductivehealth@who.int
www.who.int/reproductivehealth

World Health Organization

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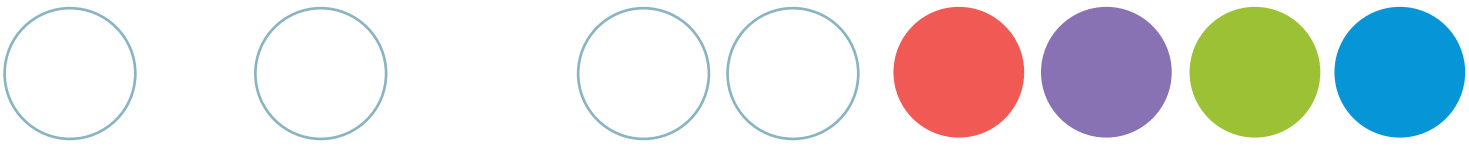

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World Health Organization (WHO)

Consultant

Deborah Hennessy

Staff

Mouzzam Ali
Maia Ambegaokar
Islene Araujo de Carvalho
Narimah Awin
Rebecca Bailey
Valentina Baltag
Katherine Ba-Thike
Augusta Biai
Paul Bloem
Dalia Brahmi
Nathalie Broutet
Victoria Camacho
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Lale Say
Ivelise Segovia
Olive Sentumbwe-Mugisa
Luis Seoane
Suzanne Serruya
Cladimir N Shchigolev
Bente Sivertsen
Shyam Thapa
Margaret Usher-Patel
Erica Wheeler
Jean Yan
Jelka Zupan
Severin Ritter Von Xylander

Abbreviations

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
BCG	bacillus Calmette–Guérin
FP	family planning
GBV	gender-based violence
HIV	human immunodeficiency virus
HPV	human papillomavirus
HRD	human resource development
ICM	International Confederation of Midwives
ICPD	International Conferences on Population and Development
IPT	intermittent preventive treatment (for malaria)
IUD	intrauterine device
LAM	lactational amenorrhoea method
LBW	low birth weight
MCH	maternal and child health
MDG	Millennium Development Goal
NGO	nongovernmental organization
PAP smear	Papanicolau test
PHC	primary health care
PMTCT	prevention of mother-to-child transmission
PPH	postpartum haemorrhage
RH	reproductive health
RHR	WHO Department of Reproductive Health Research
RTI	reproductive tract infection
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
USSR	Union of Soviet Socialist Republics
UTI	urinary tract infection
VA	vacuum aspiration
VIA	visual inspection with acetic acid
WHO	World Health Organization

Glossary of terms

Whenever possible, definitions have been taken or adapted from WHO publications; some are composite definitions.

Ability
The quality of being able to perform; a natural or acquired skill or talent.

Acting in the best interest of the child and adolescent (aged 10–19)
The decisions and actions of health-care providers have only one criterion – the best interests of their child/adolescent patients. Every decision and every action is based on a thorough assessment of the patient's condition and social context, as well as a careful consideration of the views of the patient. This is particularly important if there is tension between the child/adolescent and their family/community.

Attitude
A person's views (values and beliefs) about a thing, process or person that often lead to positive or negative behaviour.

Behaviour
A person's way of relating or responding to the actions of others or to an environmental stimulus.

Competence
Sufficient knowledge, psychomotor, communication and decision-making skills and attitudes to enable the performance of actions and specific tasks to a defined level of proficiency.

Competent
The successful demonstration of essential knowledge, skills, attitudes and professional behaviour on a specific task, action or function in the work setting.

Continuity
The ability of relevant services to offer interventions that are either coherent over the short term both within and among teams (cross-sectional or horizontal continuity), or an uninterrupted series of contacts over the long term (longitudinal continuity).

Core competency
Identifies units of competency that an industry (health, education etc.) has agreed are essential to be achieved by a person to provide quality services.

Coordination of care
A service characteristic resulting in coherent treatment plans for individual patients. Each plan should have clear goals and the necessary and effective interventions. Cross-sectional coordination means the coordination of information and services within an episode of care. Longitudinal coordination means the interlinkages among staff members and agencies over a longer period of care.

Counselling
Counselling refers to a process of interaction, a two-way communication, between a skilled provider, bounded by a code of ethics and practice, and client/s. It aims to create awareness of and to facilitate or confirm informed and voluntary sexual and reproductive health decision-making by the client. It requires empathy, genuineness and the absence of any moral or personal judgement.

Disadvantaged marginalized groups
A term applied to groups of people who, due to factors usually considered outside their control, do not have the same opportunities as other groups in society. Examples might include unemployed people, refugees, street children, individuals with disabilities, physically and mentally challenged, people living with human immunodeficiency virus (HIV), adolescents, sex workers and others who are socially excluded.

Ethics

Comprises four principles:

- respect for persons: the duty to respect the self-determination and choices of autonomous persons, as well as to protect persons with diminished autonomy. Respect for persons includes fundamental respect for the other; it should be the basis of any interaction between professional and client;
- beneficence: the obligation to secure the well-being of persons by acting positively and maximizing the benefits that can be attained by the client;
- non-maleficence: the obligation to minimize harm to persons and, wherever possible, to remove the causes of harm altogether;
- proportionality/justice: the duty, when taking actions involving the risks of harm, to balance risks and benefits so that actions have the greatest chance to result in the least harm and the most benefit to persons directly involved.

Evolving capacity

Health professionals provide adolescent clients and people who are intellectually disadvantaged with age-appropriate and developmentally appropriate information, check understanding, encourage questions and respond to them fully, supporting age-appropriate and developmentally appropriate decision-making. Health-care providers take into account that as an individual grows and develops through adolescence, his/her ability to know and understand issues, and to make well-considered decisions grows.

Gender

The socially constructed roles, behaviours, activities and attributes that are considered by a society to be appropriate for its men and women. People are born female or male but learn to be girls and boys who grow into women and men. This learned, socially reinforced, and often legally enforced behaviour delineates gender roles and relationships.

Gender analysis

The systematic examination of gender norms, roles and relations between women and men, and consequent differentials in privileges, power and control of resources. It identifies, analyses and informs action to address health inequalities that arise from the different roles of women and men, or the unequal power relationships between them, and the consequences of these inequalities on their health.

Gender sensitive

Considers gender norms, roles and relations, and does not address inequalities generated by unequal norms, roles or relations. Indicates gender awareness, though often no remedial actions are developed.

Knowledge

A fund of information that enables an individual to have confident understanding of a subject, with the ability to use it for a specific purpose.

Leadership to make health authorities more reliable

Reforms to replace disproportionate reliance on “command and control” on the one hand, or “laissez-faire” disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership required by the complexity of a contemporary health system.

Primary care

Primary care is a component of primary health care, and usually refers to the first level of contact people have with health-care teams. In some countries this can be the community health worker or the midwife. In others this refers to the family practitioner.

Primary health care

The aim of primary health care (PHC) is to ensure that all people, both rich and poor, are able to access the services necessary for realizing the highest level of health. It includes organizing the health system to provide quality and comprehensive health care for all people, and ensuring that the poor and other disadvantaged people have fair access to essential health services. PHC mobilizes the society and requires community participation in defining and implementing health agendas, and encourages an intersectoral approach to health. PHC positions health development into the overall social and economic development of countries.

Professional practice

Accepted behaviour that is based on codes of conduct, custom, guidelines, manners, protocols, social codes, social procedures and standard procedures.

Public policy to promote and protect the health of communities

Reforms to secure healthier communities, by integrating public health actions with primary care and pursuing healthy public policies across all sectors.

Quality care

Striving for and reaching agreed levels of care that are accessible, equitable, affordable, acceptable/patient centred, effective, efficient and safe.

People-centred health systems

Reforms that reorganize health services as primary care, i.e. around people's needs and expectations, so as to make them more relevant and more responsive to the changing world, while producing better outcomes.

Reproductive health

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so.

Reproductive health care

In line with the definition of reproductive health, reproductive health care is defined as a constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

Reproductive rights

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

Sex

Refers to the biological characteristics that define humans as female or male, which are biologically determined.

Sexual health

A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.

Sexuality

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, intimacy and reproduction. It is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

Skill

Ability learned through education and training, or acquired by experience, to perform specific actions or tasks to a specified level of measurable performance.

Standard

A norm/uniform reference point that describes the required level of achievement (performance) for a defined task.

Task

A defined piece of work with a well-defined purpose, which is often required to be completed within a certain time frame. Tasks are carried out by an individual or a group of providers. Other groups have used the term "intervention" or "practice" to name the same concept.

Universal access to sexual and reproductive health

The equal ability of all persons, according to their need, to receive appropriate information, screening, treatment and care in a timely manner, across the reproductive life course, that will ensure their capacity, regardless of age, sex, social class, place of living or ethnicity, to:

- decide freely how many children to have and when to have them, and to delay or prevent pregnancy;
- conceive, deliver safely and raise healthy children, and manage problems of infertility;
- prevent, treat and manage reproductive tract infections and sexually transmitted infections, including HIV/acquired immunodeficiency syndrome (AIDS), and other reproductive tract morbidities, such as cancer;
- enjoy a healthy, safe and satisfying sexual relationship, which contributes to the enhancement of life and personal relations.

Unmet need for family planning

An unfulfilled desire to delay or stop childbearing. Demographers and health professionals use the term to indicate the number or percentage of married women who say they prefer to avoid a pregnancy but do not use any method of contraception.

Vulnerability

Vulnerability is the state of being unable, or deprived of the means, to enjoy or benefit from basic facilities available to the rest of the community members. Vulnerable groups include: children, pregnant women, adolescents, persons with disabilities, old persons, migrants etc.

"Attitudes, tasks, knowledge and skills that health personnel in PHC may need, to protect, promote and provide SRH in the community"

1. Introduction

The *core* sexual and reproductive health (SRH) competencies that are desirable for use in primary health care (PHC) are collected together in this document. They reflect the attitudes, tasks, knowledge and skills that health personnel in PHC may need, to protect, promote and provide SRH in the community. These competencies serve as the first step for policy-makers, planners, service organizations and academic/training establishments, to understand and meet both the education/training requirements and the service-delivery support needed by SRH staff to provide safe, quality SRH care.

The competencies have been developed through a technical consultation of SRH experts in research, education, policy and service, over more than two years. The consultation included two workshops and many rounds of review in a Delphi-research-style process. A survey on the role of PHC providers in SRH was also undertaken to inform the competency definitions.

Each country can use the competencies to clarify and match competencies with job descriptions of different health providers working in the SRH team in PHC. We expect local health managers to support service personnel in the field by ensuring that they have job descriptions reflecting the competencies required in their SRH role and that they have the updating and supervision necessary. This may also mean that standards and guidelines need to be updated. The competencies should then be the starting point for the education/training curricula of SRH providers.

The background in Section 2 explains the World Health Organization's (WHO's) increasing focus on SRH. Section 3 exposes the gradual development of PHC over the past 60 years and its interaction with the rise of SRH and human rights. Section 4 discusses the importance of good policies, planning, training and education strategies to support and enable competent SRH providers. The competencies themselves are discussed in Section 5. A conclusion is presented in section 6 followed by a detailed presentation of the domains or groups of competencies. ❖

2. Background

The eight Millennium Development Goals (MDGs) agreed by the United Nations (UN) World Summit in 2000, were widely acclaimed as a landmark for the 21st century *(1).* Nevertheless, several international organizations were disappointed that SRH had not been explicitly mentioned in the MDGs. With the influential support of WHO, they embarked on a lobbying campaign to persuade the UN to include reproductive health (RH) in the MDGs by the time of the UN's next World Summit, which was scheduled for 2005. The campaign gave WHO the opportunity it needed to raise the profile of SRH in the public perception of what health care should be. In 2004, the World Health Assembly accepted the first RH Strategy *(2)*, drawn up by the WHO Department of Reproductive Health Research (RHR), thus sending a strong message to countries that they should:

> ***. . .make reproductive and sexual health an integral part of national planning and budgeting, to strengthen the capacity of health systems, and to ensure all aspects of reproductive and sexual health are included with national monitoring and reporting (footnote 2, page 8).***

After many years, WHO was in a stronger position to promote sexual and reproductive health care as the key to improving the general health of a nation's population. One of the main outcomes of the 60th General Assembly of the UN held in 2005 was a resolution for all countries of the world "to achieve universal access to RH by 2015" *(3)*. SRH was to be delivered through PHC, integrated with the strategies to attain the internationally agreed MDGs, and all this was to be done within the context of human security and human rights.

To achieve universal access to SRH by 2015, national health-care systems must increase their drive and plans to provide a well-functioning service for the action-oriented and inclusive delivery of SRH care by a competent workforce. The latter must have the competence (knowledge, skills and attitude) and the means (motivation, setting, medical commodities, tools and job aids etc.) to provide an appropriate basic SRH package. Capacity-strengthening is therefore a main component of SRH strategic work and includes strengthening the capacity of health systems, as well as planning for and funding the training and education of health workers.

The 25th and 26th meetings of the Sexual and Reproductive Health Scientific and Technical Advisory Group (*4, 5*) recommended the "continuation of work on defining core competencies (clinical, management, counselling) for health care providers in sexual and reproductive health". Therefore, the RHR led the development and definition of the core SRH competencies that should be integrated into the provision of PHC. ❖

3. Primary health care and sexual and reproductive health

This section explains the development of PHC since the 1970s, culminating in the document *Primary health care: now more than ever*, in 2008 *(6)*. It also explains the background and development of SRH in PHC and includes a section on human rights and SRH. The years of development emphasize why it is imperative, in 2010, for countries to offer a pathway to a better life by really focusing on SRH, in order to reach the 2015 MDG targets.

3.1 Primary health care as a means to achieve health equity and provide universal access to sexual and reproductive health

During the years immediately following the Second World War, economic development gained a new momentum. Social development was expected to follow in the wake of economic development. Health care in particular was seen to be an optional extra that a nation could choose to add on to its development once its economic growth was assured.

It became apparent in the 1970s that social development was not following economic development automatically. The gap between rich and poor continued to widen. Many people did not have access to clean water, adequate food, fuel, transport and ultimately to health care. Furthermore, the health-care systems that had developed by that time were disappointing. WHO described them as overly reliant on outside vertical interventions, and based on large urban hospitals that offered curative care to those who could reach them *(7)*. But such health-care systems were unable to provide care for the total population and did not focus on health promotion.

In 1974, after recognizing earlier failures in health-care systems, WHO and the United Nations Children's Fund (UNICEF) carried out an international review *(8)*, and reported that several countries had pioneered programmes in PHC. Evaluation of these indicated that PHC was able to address the challenges by providing appropriate and locally based services that were integrated into economic development. This finding started the search for a new approach to health care.

In 1977, the 30th World Health Assembly approved a resolution that "the main goal of WHO and governments should be the attainment by all citizens in the World by the year 2000, of a level of health that would permit them to lead socially and economically productive lives" *(9)*. This gave birth to the global goal of health for all by the year 2000 *(10)*. In the following year, WHO and UNICEF organized a joint international conference in Alma-Ata in the former Union of Soviet Socialist Republics (USSR), to discuss how the new global goal and the eight essential services and three principles of service provision might be reached. (see Box 1)

3.2 The World Health Organization 2008 report

On 14 October 2008, WHO returned to Alma-Ata – now Almaty in Kazakhstan – to launch its World Health Report in commemoration of the 30th Anniversary of its "health-for-all" declaration. The report, entitled *Primary health care: now more than ever (6)*, makes the case for revitalizing the PHC approach as a means of strengthening health-care systems.

In the report, it is clear that increased health-care expenditure in itself is not enough to solve the problems with health-care provision. The root of the problem appears to be the lack of investment in publicly funded *comprehensive* services. Further, the same reviews indicate that PHC is the type of health-care provision most likely to address the global issues and problems that now face us. Therefore, in order to meet the challenges of today's world while staying focused on its original values, WHO sets out four main reforms to the PHC concept (see Box 2).

Box 1 The primary health-care concept [1]

The eight essential services

1. Education about prevailing health problems and methods of preventing and controlling them
2. Promotion of food supply
3. Adequate supply of safe water and basic sanitation
4. Maternal and child welfare (including family planning)
5. Immunization against infectious diseases
6. Prevention and control of endemic diseases
7. Appropriate treatment of common diseases and injuries
8. Provision of essential drugs

The principles of service provision

- Intersectoral and agency collaboration
- Community participation where people have control over their own lives and health
- The reorientation of the national health-care system towards primary health care

[1] Derived from many sources and quoted in Kesby, S.G., Primary Care as a Transcultural System, paper presented to the healthcare conference organized by the Hospital Albert Schweizer Alumni Association, Pittsburgh, USA, August 1992. [11]

In the WHO 2008 report *(6)*, health-care development was recognized in varying degrees to be nonconsistent with the PHC concept. Further, much of the early progress made after the Alma-Ata Declaration has now been lost. Ironically, economic prosperity and recession have both been used by governments as reasons to neglect health. In addition, low-income countries – mostly in Africa – have seen little or no health-care development.

3.3 The rise of sexual and reproductive health care

In developing countries in the 1960s, the approach to health care and to RH was a vertical one: the concern that population growth would always outstrip any achieved economic growth, led to a proliferation of family planning (FP) campaigns limited to reducing fertility by widespread distribution of only one or two methods of contraception. Such campaigns were often designed, funded and delivered as vertical programmes by the government departments of the developed countries, and/or by, aid agencies and international nongovernmental organizations (NGOs). In addition, outside donors for FP programmes mostly worked in isolation from one another, even when providing similar programmes in the same country. Therefore, it was left to the recipient developing country to integrate FP programmes into its existing health-system provision. However, at the time, health care in these countries had yet to develop to a stage where they could absorb and make full and sustained use of any kind of vertical programme.

Notwithstanding the limitations, the world continued to use the vertical approach to health care for many more years, even after WHO

Box 2 The four primary health-care reforms

1. **Universal coverage to improve health equity**
   Reforms to ensure health-care systems contribute to equity and social justice, and end exclusion, primarily by moving towards universal access and social and health protection
2. **Service delivery to make health systems people centred**
   Reforms to ensure health-care systems contribute to equity and social justice, and end exclusion, primarily by moving towards universal access and social and health protection
3. **Public policy to promote and protect the health of communities**
   Reforms to secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across all sectors
4. **Leadership to make health authorities more reliable**
   Reforms to replace disproportionate reliance on "command and control" on the one hand, and "laissez-faire" disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership required by the complexity of contemporary health-care systems

Source: *(6)*

introduced PHC through the Alma-Ata Declaration in 1978. WHO continued to promote health-systems development in accordance with its founding principles: the global control of communicable disease, the promotion of health governance, and the development of health-care-delivery systems. To this end, WHO gradually expanded the idea of mere FP programmes or population control to a more comprehensive concept under the name of "sexual and reproductive health" (SRH).

3.4 The conceptualization and definition of sexual and reproductive health

In summarizing the outcomes of both International Conferences on Population and Development (ICPD) in 1994 *(12)* and 1999 *(13)*, the UN programme for action (Chapter VII, para 7.2) described SRH as follows *(14)*:

> *... reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.*

Health should be viewed as a human right that contributes to social and economic development. The good health of the individual, the family, the community and the nation depends on the quality of SRH. Expression of sexual and reproductive activities, and equal interpersonal relations between men and women should be accepted as a normal element of life and is a human right.

In the past, much of the focus of SRH was on maternal and child health (MCH), emphasizing the importance of healthy mothers as a precondition for healthy babies, as we saw earlier in the eight essential services of PHC (see Box 1). While MCH is still important, the focus of attention has now been markedly widened to include the RH of men and women throughout their life-cycle, and adolescents of both sexes. SRH extends before and beyond the years of reproduction, and it is closely associated with socio-cultural factors, gender roles and the respect and protection of human rights. Thus, SRH policies and strategies can have a major impact on the health of men, women and children, including adolescents, across their life-cycle.

The crucial role of SRH to both the general health of the population and the social and economic development of a nation, and the lessons learned from past experiences, demonstrate that MCH, family planning, abortion etc. should not be structured as a single-issue vertical programme, in the hope of bringing a quick solution to urgent problems. SRH services must be delivered as a collection of integrated services that address the full range of SRH needs. Furthermore, SRH must be part of the existing health-care system, which should play a lead role in its development, and ensure that it is coordinated with public health and primary health care, and reflects human rights.

WHO defined the above concept with a more precise description of SRH, which consists of six components, five key areas for action and partnership, and three overarching themes (see Box 3).

Box 3 The concept of sexual and reproductive health

The six components

1. Improving antenatal, perinatal, postpartum and neonatal care
2. Providing high-quality services for family planning, including infertility services
3. Eliminating unsafe abortion
4. Combating sexually transmitted infection (STI), including HIV, reproductive tract infections (RTIs), cervical cancer and other SRH morbidities
5. Promoting sexual health
6. Increasing capacity for strengthening research and programme development

The five key areas for action and partnership

A. Intersectoral and agency collaboration

B. Mobilizing political will

C. The reorientation of the national health-care system towards primary health care

D. Creating supportive legislative and regulatory frameworks

E. Strengthening monitoring, evaluation and accountability

The three overarching themes

I. Universal access to SRH, including the meeting of unmet needs

II. The renewal of PHC

III. Fostering programmatic and policy linkages between services and interventions for human immunodeficiency virus (HIV) and for SRH

Adapted from *(15)*

3.5 Integrating sexual and reproductive health within the public health-care system

The history of SRH and PHC and the similarities of the SRH and PHC concept (shown in Boxes 2 and 3) suggest that they are already integrated and that there is clarity on how and where the SRH concept fits with PHC. Despite this, in many countries there are areas where this can still be improved (refer to Section 4.3).

The renewal of PHC, the strengthening of health-systems capacity and the goal for universal coverage and access are common to both SRH and PHC concepts. Further parallels exist between the principles to make health systems "people centred"; to meet unmet needs; to foster programme and policy linkages, intersectoral and agency collaboration; to promote leadership; and to mobilize political will. Primary health care is a means for achieving health equity and providing universal access to SRH. The SRH concept is stronger on creating improved supportive and regulatory frameworks; on strengthening monitoring, evaluation and accountability; and on using research evidence to shape programme developments. All of these should also be incorporated into PHC.

3.6 Sexual and reproductive health in relation to human rights

Human rights have been applied to a wide range of SRH issues, through international human rights treaties as well as through national instruments such as constitutions and laws. The rights that are related to SRH include: the right to life, survival and development; the right to the highest attainable standard of health; the right to education and information; and the right to nondiscrimination. The latter appears in all the treaties. All countries in the world have ratified at least one of the international human rights treaties: obligating the country to respect, protect and fulfil human rights designated as described in the treaty.

Universal access to RH is found in MDG 5, target B (MDG 5B), which is clearly an aspect of the right to the highest attainable standard of health. Achieving universal access, particularly with regard to certain population groups such as youth and adolescents and the marginalized and vulnerable population groups, requires well-functioning health systems and service delivery in countries. It also requires a legal and policy environment that facilitates access and prevents any unnecessary barriers to the achievement of SRH. ❖

4. Good policy, planning and education:
the foundation of high-quality sexual and reproductive health care

Achieving MDG and SRH strategy goals requires a fresh look by each country at their policies and planning, as well as human resource development, to ensure population coverage as well as integrated and inclusive services.

4.1 Sound national policies

Successful outcomes of SRH services depend on the formulation of sound national policies that support and enable the existence of local health-care environments, which increase the coverage of services, and also competent health providers, who have the knowledge, skills and tools to carry out specific SRH tasks, working within a multidisciplinary primary health-care team approach.

To improve SRH in their country, policy-makers will make many decisions and design policies, which include:

- assessing the SRH health needs of the community using epidemiological data;
- deciding on the essential[2] SRH health packages to be delivered;
- agreeing the coverage areas and the clinical settings;
- ensuring the attendance of a skilled birth attendant at every birth;
- agreeing on the levels of education of the different health personnel who will provide SRH care;
- organizing the training and education of SRH health providers and the funding of such programmes;
- encouraging the development of clinical environments that enable staff to use their knowledge and skill of SRH and to work efficiently and competently (see Box 4).

[2] Essential health packages aim to concentrate scarce resources on the interventions that provide the best value for money. They are intended to be a guaranteed minimum and to enhance equity of access, and are not a solution for weak management.

Box 4 Good foundation policies

The policy-makers in every country need to develop specific policies for SRH services and SRH education.

1. **Policies to support SRH service managers:**

- ensure the delivery of essential SRH packages in people's homes, at health posts, health centres or elsewhere, based on an assessment of local need and using epidemiological data;
- identify those workers who will deliver this care and the place of delivery;
- ensure that adequate funds are available for service provision, which include health-worker salaries and the organizational mechanisms to provide an enabling-supportive environment and supportive supervision of their work.

2. **Policies to support the education of SRH providers so that:**

- education and training for SRH teachers, tutors and trainers is provided to improve their capacity and ability;
- preservice training and education for providers is available to ensure that the different levels of health workers develop the competence needed for their level of work;
- all the different health workers receive ongoing education to maintain and further develop their competencies;
- adequate funds are available for basic education and continuing education programmes.

4.2 A well-trained workforce

Only a well trained and competent workforce and a well-functioning health system can turn policies into action and implement the best possible practices in all settings. Without workforce capacity to deliver on vision, strategies, international agreements and national policies, the aims of the WHO Global Sexual and Reproductive Health Strategy *(16)* and MDGs 5A and 5B *(17)* will not be translated into effective practice and health improvement.

4.3 Who delivers sexual and reproductive health services in primary health care?

In 2009, the RHR undertook a survey on the role of PHC providers in SRH. The purpose was to gather information about SRH services provided in PHC, mainly in developing countries, with an emphasis on the different ways SRH in PHC is organized, what SRH services are provided in each country, where they are delivered and by which providers.

The survey focused on how SRH is being provided within PHC from the community to health-facility level. The various job positions of staff were identified, and specific questions were asked in seven technical areas as follows: antenatal care; childbirth; neonatal care; family planning and infertility care; abortion care, STI/RTI (including HIV and voluntary counselling and testing) services as well as screening for sexual violence and cancers; and sexual health education and counselling. In each of these areas the questionnaire asked for:

- information about who provided the services;
- the setting in which they were provided, for example in a health centre or in another community facility or at home;
- the degree of integration of SRH provision within PHC (a point emphasized in the publication *Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets) (16)*.

The survey questionnaire was distributed to RH focal points in WHO country offices in 97 countries. These WHO country focal persons were asked to respond to the questionnaire themselves and also to collect responses from managers in their ministry of health, from SRH service programme managers in PHC, and also from providers of SRH services.

The collected information (completed questionnaires received from 67 countries, including all six WHO regions) provides substantial evidence on the SRH services in PHC that are currently provided in countries and WHO regions. The data also point to major differences in the level of workers providing different aspects of SRH care. The data, therefore, are an excellent background for identifying the knowledge, skill, and attitudes that different health providers need to have to deliver SRH competently in PHC. A full account of the results of this survey is available from www.who.int/reproductivehealth

4.4 Making decisions about who will deliver sexual and reproductive health services in primary health care

Each country should decide which category of health worker will undertake specific SRH tasks in PHC, and the place of delivery. Where appropriate, *task-sharing can be considered*, to improve access to care for the general public. Task-sharing involves adding specific tasks to the normal activities of selected categories of qualified health workers, or delegating tasks delivered from highly educated health workers to those who have a shorter training and fewer qualifications. Proper delegation of these tasks (which has implications for preservice and in-service training for capacity-building) will make more efficient use of the available human resources for SRH at PHC level and increase access to services. The results of the survey on the role of SRH providers in PHC, mentioned in Section 4.3, can provide information on who delivers what SRH service by country, and the most dominant per region or globally.

4.5 Competence of sexual and reproductive health workers for primary health care

Frequently, health-care workers provide SRH services in primary health-care settings in rural or remote areas with limited supervision. To ensure the health and safety of women, men and children, it is of paramount importance that all workers in the SRH/PHC field are *adequately prepared, regularly supervised and supported in their work*, irrespective of whether they are nonspecialist physicians, or health personnel, who are not physicians. It is essential that countries develop an infrastructure and a supervision system that can support these health workers, ensuring that they maintain an adequate level of competence. This is especially important in the remote and rural areas where the knowledge, skill and attitudes of the health worker may be life saving, while a lack of competence could be life threatening. *The speed at which the health worker can adjust his or her skills could determine the outcome of a safe delivery or maternal death. The sensitivity and attitudes with which the health worker handles the individuals, as well as his or her knowledge of local norms and taboos, and the services that may be able to assist the health worker and his/her patient, are very important for the future well-being of the community.*

Therefore, all SRH health workers require strong preservice education and continuous lifelong education, development and support.

The *Global standards for the initial education of nurses and midwives (18)* calls for worldwide educational standards so that "the workforce can contribute to strengthening health systems to meet population health needs and protect the public. . .". These should:

- be based on evidence and competency;
- promote the progressive nature of education and lifelong learning;
- ensure the employment of practitioners who are competent and who, by providing quality care, promote positive health outcomes in the populations they serve. ❖

5. The competencies

5.1 What is competence?

Competence is the acquisition of sufficient knowledge, psychomotor, communication and decision-making skills and attitudes to enable the performance of actions and specific tasks to a defined level of proficiency. Competence is of specific concern in some professions, especially medicine, nursing midwifery and therapies *(19)*.

A person's performance must meet specific criteria before he or she can be called competent. A competent health-care provider needs to successfully perform the following while doing a job:

- carry out activities within an occupation or function;
- work consistently to agreed standards of care;
- transfer skills to a range of situations within the occupational area *(20)*.

Wocjtczak, in 2002 *(21)*, defined competence as the knowledge and skills required to perform the tasks that reflect the scope of professional practice. An important point is that if someone performs well (according to standards), they may be competent; however, a competent health worker may not be able to perform as he/she should because of issues outside their control. But, competence is not only the knowledge and skill that allows one to do something; on the contrary, it may also be about recognizing one's knowledge limits and having the skills to recognize this, as well as the right time to refer to someone else with more skill and knowledge. Competence may also be affected by aspects of the health service that block or limit the provider's ability to use their knowledge and skills correctly.

The success of SRH services that have been designed to reach specified health outcomes depends largely on health providers working in multidisciplinary PHC teams. Many health personnel, of course, work in rural areas on their own. In these situations, health personnel need to have job descriptions, standards and guidelines clarifying what is expected from them. This document is focusing on the primary health-care team approach and not on individual professions. Therefore, *the SRH competencies in this document are described as the competencies for performing essential SRH services, not for specific professions*. Nevertheless, each health worker may perform specific competencies in one-to-one interactions with clients to meet their needs, or with other health professionals. This is very important, as some health professionals and health workers might require different competencies so that, overall, the public receive comprehensive SRH care.

The competencies in this document are for adoption and adaptation in the standards and national SRH frameworks of individual countries. This is according to the context and level of practice in that country. Every country differs, providing varying levels of SRH services. Each country may also use varying combinations of health worker levels to deliver SRH services, as mentioned in Section 4.3 and also later in Section 6. Therefore, the competencies in this document are not tied to a particular level, PHC organization or health provider. Instead, these competencies are for the PHC team approach. The SRH programme manager in each country can assign competencies to whichever cadre or level of care is appropriate. Individual cadres are not expected to provide the full range of SRH care, for everyone. Nevertheless, this will mean that it is very important for individual cadres to be clear about what they are expected to provide and to know the internal referral mechanisms in the team. In order to ensure that clients receive comprehensive and continuous SRH care, all primary health-care staff at first level, for example those working in homes or clinics or the community, should be aware of the competencies available at the next higher referral level, and vice versa. Health workers also need specific competencies to be able to refer clients vertically to a higher level, and refer them back

to a lower level too. Referral can also be horizontal, for example, a pregnant woman referred from a midwife to a nurse who is a breastfeeding counsellor.

Country counterparts may need to keep all this in mind when making decisions about which cadre should deliver specific SRH care and in which setting, and also when preparing SRH-provider educational curricula.

In each country, strong national leadership is essential to build up the capacity and competence of the workforce who can deliver high-quality SRH care. This is fundamental to the successful implementation and quality outcomes of SRH in each country *(7)* and the effectiveness of the global SRH strategy. To deliver the strategy, the health workers carry out a range of tasks, including: assessing the SRH needs of the client; observing their behaviour and health; providing information, teaching and counselling the client; and also at times carrying out technical interventions such as assisting at a delivery or taking blood and testing it for abnormalities. The outcome of these interactions and tasks depends to a great extent on the *competence* of the health-care provider.

5.2 The development of core sexual and reproductive health competencies

To improve outcomes of SRH care, many different organizations and programmes that are active in SRH provision have developed *core* competencies, for specific SRH areas, such as: family planning; maternal and child health; STIs and HIV; and human rights. Others have developed competencies for specific professional groups. In 1999, the Consultative Group on Midwifery Skills for Reproductive Health in the Americas prepared a document called *Essential competencies suggested for health workers providing comprehensive reproductive health services (22)*. The International Confederation of Midwives (ICM) is currently revising their "Essential Competencies for Basic Midwifery Practice" through a worldwide Delphi research process; these are detailed competencies, specifically for midwives (due to be completed towards the end of 2010). The ICM competencies will be particularly useful for midwifery education.

Several countries expressed a need for integration of the SRH competencies, and so RHR developed the core list of competencies attached to this document. The competencies in the attachment to this document bring together the core competencies that are needed to achieve universal access to integrated SRH in PHC. To our knowledge, there has not been another international effort to do this. This list has been underpinned by an extensive review and consultation by world experts in their subject and built up over a two-year process of acceptance. The reviewers included academics, clinicians, policy-makers and managers, representing all WHO regions, member countries, and NGOs.

These competencies can be described as the minimum package of SRH care that all clients should be able to access, regardless of their social, physical and mental status, sex, age (there is a strong emphasis on the proper provision of SRH for adolescents), religion, and also which country and which part of the country they reside in.

It is anticipated that these competencies will:

- establish a global approach to the provision of evidence-based education for SRH workers;
- provide a guide to establish competency-based SRH curricula;
- be used by all SRH training and education providers, whether governmental, nongovernmental, NGOs or donor agencies;
- ensure that all SRH training and education meets national, regional and society needs and expectations;
- establish benchmarks for continuous quality improvement and the progression of SRH training and education.

The competencies

There are 13 competencies grouped into four domains:

1 The first domain is the overarching attitude, which builds on SRH workers' knowledge of ethics and principles, and thus becomes the "sine qua non" (essential item) for the fulfilment of the individual client's human rights. Domain 1 is not actually a group of competencies, but the fundamental basis of all competencies.

2 The second domain is the leadership and managerial domain, addressed to national SRH programme leaders and managers, but which could also apply to any level including at a health facility level; it has two competencies.

3 The third domain has four general SRH competencies for health providers, including working with the community, health education, counselling, and assessment of the client.

4 The fourth domain includes seven specific clinical competencies for different types of sexual and reproductive health-care provision.

Health-care personnel may require a range of competencies from different domains. For example, a midwife should have a full range of clinical competencies to provide competent care (Domains 3 and 4, Competencies 5–13). She may also have to inform and sensitize the community to SRH issues (Domain 3, Competency 3), advocate for women's rights (Domain 1), refer a mother for a higher level of care (Competency 6) and manage and store her stock of drugs and contraceptives (Competency 2), etc.

Each of the four domains includes a description of each competency, each with associated tasks, knowledge, and skill (the first domain includes behaviour and knowledge). We believe that the four competency domains make a contribution to the four pillars of PHC reform.

Domain 1: Attitudes for providing high-quality sexual and reproductive health care

This first domain covers essential behaviours and attitudes for all working in SRH to provide an ethically and technically sound foundation for SRH delivery. All SRH services and associated competencies should be driven by human rights and the social values of equity, solidarity and social participation. ❖

Domain 2: Competencies 1 and 2 Leadership and management

Competency 1

Perform a leadership role that provides an environment that enables primary health-care team members to perform effectively

This competency focuses on the leadership role.

Competency 2

Effectively manage the primary health-care team to allow the efficient provision of quality sexual and reproductive health services

Health-care staff with managerial responsibilities provide the focus for this competency, especially establishing a supportive and enabling environment (where staff want to work and can do so efficiently), so that staff feel valued by the organization and have the education, facilities and resources to carry out high-quality care.

From Domain 3 Competency 3 onwards, the competencies are specifically addressed to the team/providers in the field. ❖

Domain 3: Competencies 3 to 6
General sexual and reproductive health competencies for health providers

Working in and with the community, health education, counselling, assessment of the client and referral.

Competency 3

The primary health-care team member/s provide comprehensive and integrated sexual and reproductive health care, working efficiently in and with the community.

This group of tasks and related knowledge and skill support staff working within health facilities, but also encourages staff to work outside the health facilities in a variety of community settings, always involving the community in both decision-making and receiving services.

Competency 4

The primary health-care team member/s provide high-quality health education related to sexual and reproductive health and sexual and reproductive health services.

This competency supports and encourages primary health-care teams to provide high-quality health education and promotion related to SRH and SRH services, driven by human rights values; this competency emphasizes the importance of educating individuals and the community about their sexual and reproductive health and rights.

Competency 5

The primary health-care team member/s provide high-quality counselling related to sexual and reproductive health and sexual and reproductive health services.

The purpose of this competency is to enable clients to make their own decisions about their health and the SRH services they wish to receive and the choices they make.

Competency 6

The primary health-care team member/s effectively assess the sexual and reproductive health needs of users of primary health-care services for treatment and referral when necessary.

This competency should be used by all providers to identify the needs of individuals related to SRH. This is so that the SRH provider can respond accordingly to those needs with an inclusive and people-centred approach, referring to others at different levels if required. ❖

Domain 4: Competencies 7 to 13 specific clinical competencies

These competencies are all related to the knowledge and skills needed by primary health-care teams/providers to make high-quality SRH services available to individuals, and include referral when required.

Competency 7

The primary health-care team member/s provide high-quality family-planning care

The tasks in this competency enable clients to benefit from a range of options for avoiding pregnancies, spacing the pregnancies and addressing infertility problems.

Competency 8

The primary health-care team member/s provide high-quality sexually transmitted infection and reproductive tract infection care

The knowledge and skills in this competency enable staff to provide sensitive and up-to-date interventions for people with sexually transmitted and reproductive tract infections, including HIV, referring appropriately when needed.

Competency 9

The primary health-care team member/s provide screening and treatment/referral for reproductive tract cancers

This competency provide the knowledge and skills to allow human resources to screen and treat, with simple technologies, specific initial cancers of the reproductive tract.

Competency 10

The primary health-care team member/s provide high-quality comprehensive abortion care

The tasks, knowledge and skills in this competency prepare SRH staff who are competent to counsel and provide comprehensive management of abortion, referring appropriately when needed.

Competency 11

The primary health-care team member/s provide high-quality antenatal care

This competency aims to maximize health during pregnancy: educating mothers and families about pregnancy and how to stay healthy, screening for abnormalities and referring appropriately when needed.

Competency 12

The primary health-care team member/s provide high-quality care during labour, birth and immediate postpartum

The group of tasks in this competency focuses on providing the best and safest possible care for the mother and neonate during labour, childbirth and immediately after birth, referring appropriately when needed.

Competency 13

The primary health-care team member/s provide comprehensive, high-quality postnatal care for women and neonates

This competency provides comprehensive postnatal care to mothers and neonates up to the first 6 weeks postpartum, referring appropriately when needed.

The competencies in each domain are those that each country, globally, should strive to deliver, although they may be too comprehensive for some countries to provide currently.

The various tasks in the list of competencies reported above may apply to all, or different categories of, primary health-care workers.

Each country needs to decide which category/level of health worker should provide the care that is agreed as basic, and which should provide the specialist care, agreed as additional.

The 2009 survey, mentioned in Section 4.3, showed that developing countries have wide variations in assigning different health cadres for specific tasks; therefore, in this document, the competencies are not assigned to different cadre levels, but rather they are selected as the competencies required to provide the optimum SRH care as mentioned in Section 5.1.

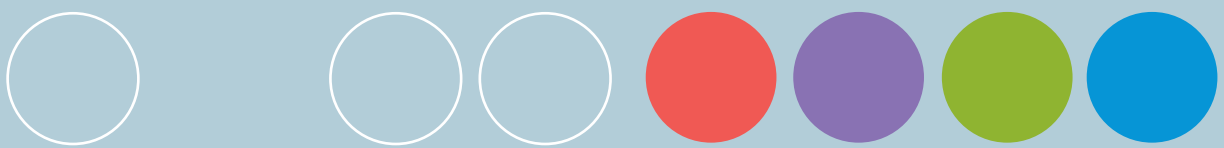
6. Conclusion

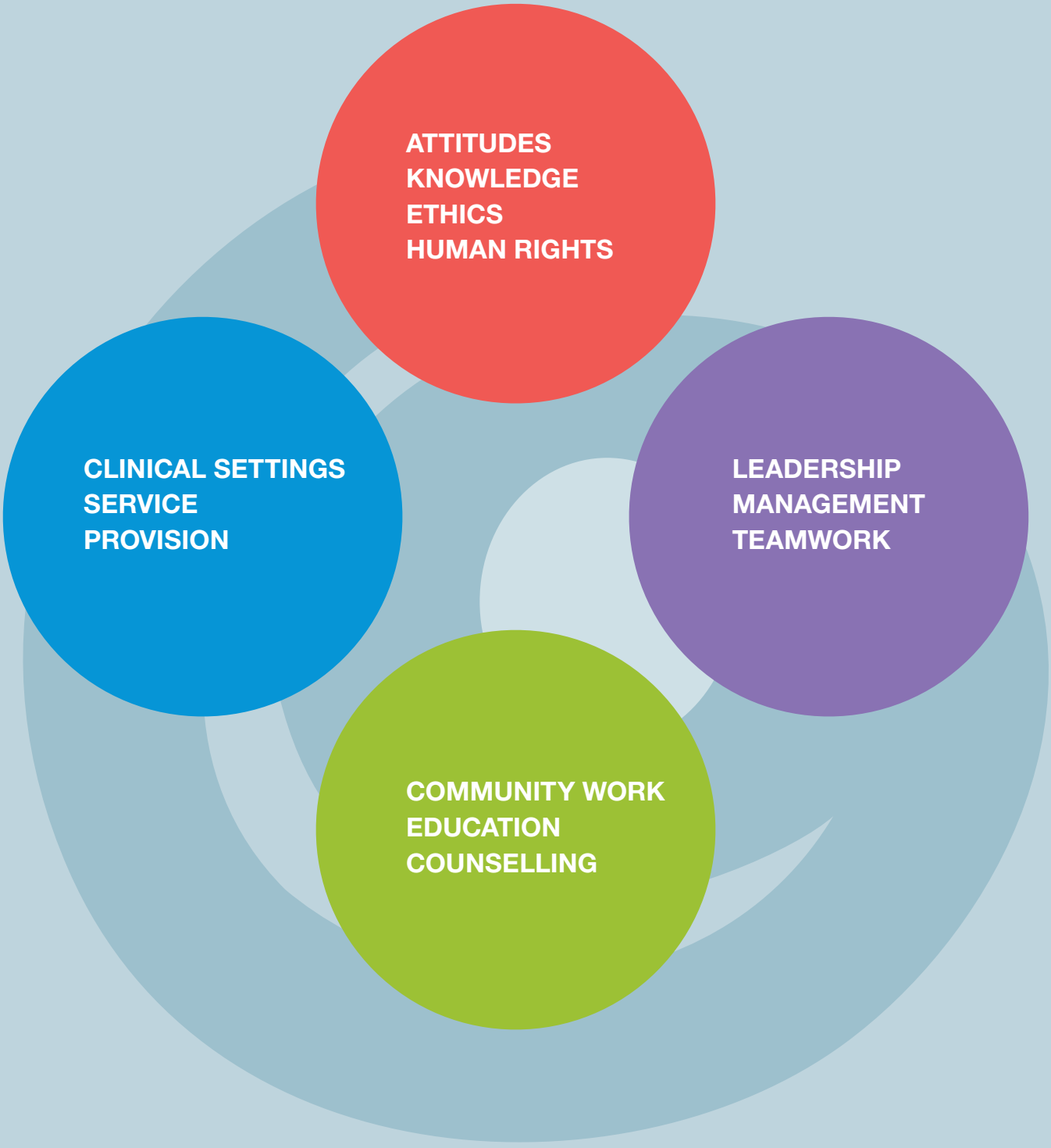
The extensiveness of SRH competencies and their potential impact on millions of people throughout the world highlights the need for the available workforce to be skilled, competent and equipped to implement national SRH policies, transforming these into effective actions tailored to the local, social, cultural, economic and political contexts, and the realities of populations, health settings and communities.

Providing an integrated RH service starts with understanding people's needs, and continues with a willingness to change the way we do things. It means listening to women and men, young people and older people (*23*).

In the light of emerging new evidence such as the information gathered during the WHO survey mentioned in Section 4.3, there will always be a need for regular international and national reviews of what constitute the core competencies in SRH and what training and education is necessary to develop the most up-to-date and competent SRH health workers.

Finally, in order to achieve the MDGs and improve the outcomes of integrated SRH in primary health care, there will have to be a major shift from the current neglected and fragmented approach to developing competent human resources (community health workers and health professionals) even in under-resourced countries. This will have to become a priority, with the development of a national SRH human resource development (HRD) plan in each country, and should include all public and private health and education sectors. The plan should have the objective of integrating, as the ideal, and mapping, as the most realistic and feasible, of all education and training resources, tools and funds received from government, donors and NGOs. The plan should be accompanied by a dedicated HRD budget which covers preservice education and training, in-service training, and the essential supportive supervision needed in the field to develop, maintain and support competent and professional health workers for SRH. ❖




ATTITUDES
KNOWLEDGE
ETHICS
HUMAN RIGHTS
CLINICAL SETTINGS
SERVICE
PROVISION
LEADERSHIP
MANAGEMENT
TEAMWORK
COMMUNITY WORK
EDUCATION
COUNSELLING

Sexual and reproductive health care: core competencies in primary care

The following is a comprehensive list of the attitudes and 13 competencies required for the effective provision of high-quality sexual and reproductive health (SRH) services by the SRH team at the primary health-care level.

These competencies are divided into four domains:

Domain 1: Attitudes for providing high-quality sexual and reproductive health care

The area builds on the SRH worker's knowledge of ethics and human rights principles, and thus becomes the "sine qua non" for the fulfilment of the individual's human rights. It is not actually a group of competencies, but the fundamental component of all the competencies. All health human resources should demonstrate these attitudes to deliver ethical, effective, appropriate and technically sound SRH services.

Domain 2: Leadership and management

This applies to national SRH programme leaders and managers (for example the district management team). It can also apply to a professional in a health facility. This group of competencies focuses on establishing and maintaining an enabling environment to assist the primary health care (PHC) team to work efficiently in providing SRH services.

Domain 3: General sexual and reproductive health competencies for health providers

This domain aims to ensure that health providers work efficiently – both in and with the community – to provide health education, to offer quality counselling and to assess the SRH needs of users and refer them properly, if needed.

Domain 4: Specific clinical competencies

This addresses specific competencies for different types of SRH care provision. These competencies assist health personnel to provide high-quality SRH services to individuals, from assessment of their need to provision of specific SRH services and/or referral.

Domain 1: Attitudes for providing high-quality sexual and reproductive health care	
A fundamental component of all competencies	
Behaviour	**Knowledge**
Treat each individual with full respect for her/his human rights	Human rights and their national, regional and international sources National laws that enhance or hinder human rights
Act consistently in accordance with personal and professional ethics and standards	Medical ethics and professional codes of conduct, and familiarity with the four principles of medical and health ethics – do no harm, do good, respect and justice
Approach all clients including marginalized and vulnerable populations in a nonjudgemental and nondiscriminatory manner, respecting individual dignity	• The right of individuals to be treated with respect, free of judgment or discrimination, regardless of their sex, age, ethnicity, sexual orientation and other status • The gender-equality principle • How to identifiy and respect gender differences and gender diversity • The marginalized and vulnerable populations in the country and local areas and their specific SRH needs • Human rights and national laws with special regard to issues related to adolescents • Diversity in beliefs and value systems
Show respect of knowledge and learning styles of individuals	• Different learning styles • Different teaching techniques and methods that facilitate learning
Demonstrate empathy, reassurance, non-authoritative communication and active listening	• Positive communication methods
Show respect for clients' choices as well as their right to consent and refuse physical examination, testing and interventions	• SRH choices available for clients and the right of individual decision-making • The principle of informed consent and procedures for obtaining clients' consent
Offer services that are confidential and provide privacy	• The principles of confidentiality and privacy and their application to SRH
Accountability and transparency in all actions	• The principles of accountability and transparency • The content and meaning of the respect, protection and fulfilment of human rights
Seek opportunities for continuous learning and professional growth	• The importance of continuous education and professional growth to maintain standards
Develop and promote effective relationships with team members and colleagues	• Team-work advantages and team-building processes
Ensure sound clinical judgement and attention to detail in all SRH care	• All the above and the most up-to-date SRH competencies

Domain 2: Leadership and management	
Competency 1: Perform a leadership role that provides an environment that enables health-care team members to perform effectively	
Task	**Knowledge, skills**
1. Perform a leadership role	Knowledge: • leadership principles • team approach • health systems: the national and local context • gender differences and gender diversity • importance of a gender perspective to meet public health objectives and outcomes. • gender mainstreaming planning • concepts of programme emergency preparedness and recommended actions • coordination and integration in a continuum of care Skills – ability to: • provide leadership through: – strategic thinking – motivating and inspiring staff and others – developing a shared vision and mission of SRH services – communicating effectively – resolving conflicts • lead networking and advocacy activities • work towards reducing gender inequalities • engage with communities and all levels of system • supervise

Competency 2: Effectively manage the primary health-care team to allow the efficient provision of quality sexual and reproductive health services

Tasks	Knowledge, skills
1. Perform a public health role, fostering SRH coordination, integration and continuity of care	Knowledge: • concepts of public health • social determinants of health as legal, political, cultural and financial systems affecting health, with specific focus on SRH • the impact of health-care-delivery systems on populations and individuals receiving SRH care • concepts of non-clinical disasters emergency preparedness, e.g. earthquakes or major floods • roles of government, private sector and nongovernmental organizations (NGOs) in the delivery of SRH in PHC • local stakeholders to promote SRH and integrated care in the community Skills – ability to: • tailor the delivery of SRH care on individual and populations' needs • develop plans for individual patients' care, with clear goals and the necessary effective integrated interventions • recognize the effects of one's own gender identity and biases on public health work • foster the development of communication and advocacy skills to become gender-competent agents of change • identify where services integration is necessary and possible • act in response to natural or conflict emergencies
2. Guide financial planning and management to provide adequate transparency and information to make effective services available	Knowledge: • financial planning, budgeting and reporting procedures – national and local • costing and expenditure-monitoring procedures • concept of transparency about the way programme finances are used • needs, availability and suitability of functional SRH health facilities

	Skills – ability to: • recognize the impact of a well-functioning health system, including allocation and budgetary issues and the implications of other social sector allocations for gender equity in public health • develop an integrated SRH budgeted plan • manage the implementation of a SRH budgeted plan • mobilize resources locally
3. Foster teamwork while managing human resources	Knowledge: • regulations and laws defining health-worker roles • individual cadres' job descriptions • employment regulation and staff recruitment procedures • supportive supervision methods • different education systems for health-care providers and their qualifications (competence to practice) • training needs analysis • assessment of the developmental needs of staff • conflict-resolution principles • workplace service-delivery norms and standards Skills – ability to: • identify the SRH roles of the different cadre of workers in the PHC team • identify a human-resource competency gap through comprehensive training needs analyses • develop and provide, in collaboration with local partners, comprehensive plans for continuing education for SRH • provide supportive supervision to ensure quality standards • advocate for national policy in support of competency-based training curricula • use evidence to inform professional educators in preservice training of the need to prepare a workforce that is "fit to practise" and responsive to the SRH needs of communities • negotiate with professional associations about professional roles for SRH (task-sharing etc.) • advocate with local community and/or government sources to provide adequate compensation/ rewards for SRH community health workers • involve the community in staff-retention strategy

Competency 2 - continued

4. Information generation and use	Knowledge: • SRH and gender indicators for monitoring information, research, policies and programmes • data-collection tools • the relationship between field data and national data: the two-way information system • how to collect, analyse and interpret local health statistics data • how to interpret age- and sex-disaggregated data • how to use data to inform decision-making Skills – ability to: • gather information using data-collection tools, • ensure accurate and complete record-keeping and timely reporting • analyse and present data in an easy, understandable way • use information to make changes and enhance the quality of SRH services
5. Management of the health facility and the logistics of supplies/equipment	Knowledge: • safe health-facility physical structures, organization of services, patients' flow, confidentiality needs, etc. • environmental sanitation • waste management and disposal • quality-assurance and patient-safety models and procedures • different procurement mechanisms • storage and proper and timely distribution of supplies Skills – ability to: • ensure the availability and maintenance of appropriate physical facilities to provide quality SRH services • ensure routine maintenance and care of the surgical instruments • ensure the availability of guidelines for providers • make timely requests for supply and resupply of commodities, drugs, medical and surgical equipment, so that stocks are always available • correctly use and perform regular maintenance of equipment • ensure regular monitoring of the health-facility status and its equipment • ensure regular monitoring of the purchase and logistics of drugs, and consumable and surgical equipment

6. Guide the implementation of SRH strategy and the provision of SRH integrated services	Knowledge: • national and local SRH policies, standards and protocols • research results to improve SRH programme implementation through evidence • programme-management cycle and monitoring and evaluation theories • the cost-effectiveness • the concepts of linkages and integration as applied to SRH and PHC Skills – ability to: • develop feasible operational plans based on available resources • operationalize the steps/functions effectively • develop/adapt and implement an evaluation framework • develop/adapt and implement strategies for comprehensive referral systems • develop/adapt and monitor the implementation of effective practice guidelines • develop performance-management guidelines/checklists using agreed clinical and other indicators • delegate authority when appropriate

Domain 3: General sexual and reproductive health competencies for health providers	
Competency 3: The Primary health-care team member/s provide comprehensive and integrated sexual and reproductive health care, working efficiently in and with the community	
Tasks	**Knowledge, skills**
1. Recognize health concerns in the community through capturing information on perceived needs, directly from the women, men, family, and community, and from other data	Knowledge: • individual and family life-cycle • SRH definition • principles of SRH and PHC • social determinants of health and illness and health inequity • information and data to be collected to obtain a community profile including health concerns, needs, assets and resources • gender issues and specific related issues in the local community • the principles of community engagement Skills – ability to: • approach and engage the community in the collection discussion and analysis of data and processes • approach and engage key informants and influential groups, fostering links • approach issues with a gender-sensitive perspective • listen, communicate, respond and interact with key members and groups in the community
2. Develop comprehensive approaches for integrated SRH at community level	Knowledge: • principles of community-based service delivery • factors influencing the delivery and use of health services • how to respond to the identified SRH needs of the community making use of their skills and resources • the advantages of integration Skills – ability to: • implement a participatory planning process for SRH care • identify and optimize opportunities for linkages, coordination and preferably integration with programmes such as maternal and child health (MCH), sexually transmitted infection (STI)/human immunodeficiency virus (HIV) and others • identify and use culturally acceptable and relevant approaches

3. Facilitate the community learning about health-promoting and preventive care	Knowledge: • health-promotion and health-protection principles and methods • effective communication methods with the community and groups • the social determinants for SRH, including barriers and facilitating factors • Skills – ability to: • be and support agents of change • prepare effective health-promotion messages • deliver effective communication of messages
4. Promote SRH working with the community to raise awareness on the importance of equity and universal access to SRH	Knowledge: • principle of universal access and its meaning in the local context • health-promotion and prevention principles, main theories and processes • strategies for health protection and promotion • key stakeholders and their influence Skills – ability to: • Identify target users' groups • Identify populations at risk (marginalized and vulnerable groups) • motivate and mobilize community leaders, community members and populations at risk (marginalized and vulnerable groups) • negotiate with key stakeholders
5. Promote self-health care	Knowledge: • self-empowerment strategies enabling people to care for themselves and to be and stay healthy Skills – ability to: • identify and support social networks, such as mothers' and youth groups, and other local initiatives

Competency 3 - continued

6. Enable the use of SRH services by the community	Knowledge: • health-promotion and prevention concepts and methods Skills – ability to: • organize and facilitate meetings within the community to be able to respond to their needs by service provision • identify and facilitate the removal of barriers and stigma

Competency 4: The primary health-care team member/s provide high-quality health education related to sexual and reproductive health and sexual and reproductive health services

Tasks	Knowledge, skills
1. Assess the local sociocultural, legal and gender concerns and issues related to programme implementation and service provision	Knowledge: • the most common health needs of the community • diverse SRH service needs for different groups, inclusive of the vulnerable and marginalized, at different points in the life-cycle • laws and policies governing SRH • laws regarding family planning, abortion, HIV, violence against women and sexual violence, sex work, sexuality (including sexual orientation and gender identity) adolescents' access to SRH services (including age of consent, best interest, evolving capacity) and marriage • local culture and social norms relevant to SRH (including harmful practices) • sociocultural barriers to the use of SRH services • SRH services offered, staff job descriptions, referral systems • health-care providers' legal obligations • health-care system (facilities available for the community, and health-services options for clients) • health systems and existing resources for social support • key elements of SRH services and national guidelines • environmental and SRH educational needs assessments • gender analysis of current programmes • gender mainstreaming as a means to strengthen programme efficacy • the economic impact or cost of various health-care options

	Skills – ability to: • carry out environmental and SRH educational needs assessment • provide culturally and gender-appropriate information • empower individuals or groups to make informed decisions
2. Create an environment that is conducive to learning	Knowledge: • basic principles of how people learn (adults, adolescents and children) • factors facilitating and impeding learning • models for behavioural change • learning outcomes Skills – ability to: • plan effective learning sessions (individual or group) to achieve learning outcomes • create secure, safe and effective learning spaces • assemble the appropriate educational materials related to SRH (for adults, adolescents and children) • share knowledge with team members and colleagues
3. Facilitate learning using a variety of techniques (discussion, demonstration, presentation)	Knowledge: • different evidence-based educational methodologies; the advantages and disadvantages of each • the “behaviour, change and communication” concept and methods Skills – ability to: • use appropriate educational technique
4. Convey essential information related to specific SRH topics	Knowledge: • SRH topic in the area being taught (cross-reference to content) • how to present a topic • linkages with other SRH topics and areas • Skills – ability to: • communicate information on SRH and related services in a simple manner, using appropriate language • adapt information or training to individual, large or small groups’ needs • make effective, easy-to-understand linkages with other related programmes

Competency 4 - continued

5. Assess the transfer of learning	Knowledge: • formative and summative assessment techniques Skills – ability to: • adapt/develop tools and techniques used to assess learning • administer tools and techniques used to assess learning • adjust teaching strategies to the assessment results • use assessment and feedback to help all learners master SRH content

Competency 5: The primary health-care team member/s provide high-quality counselling related to sexual and reproductive health and sexual and reproductive health services

Tasks	Knowledge, skills
1. Plan a counselling session including the creation of a conducive counselling environment	Knowledge: • the physical, social, cognitive and emotional development of different life stages, including adolescence • factors that facilitate and impede counselling, such as privacy, environment, time, etc. • decision-making processes • behavioural-change theories • health-seeking behaviour Skills – ability to: • plan an effective counselling session • create a secure, safe and effective counselling space • assemble the appropriate counselling materials or aids related to SRH

2. Counsel effectively	Knowledge – in addition to knowledge for Task 1: • basic evidence-based counselling techniques • mechanisms of support available for those providing counselling Skills – ability to: • communicate with individuals effectively, demonstrating awareness of gender and cultural differences while providing appropriate information. • provide information to empower individuals or couples to make informed decisions • discuss the impact of gender-based societal and cultural roles and context on health care and on women's and men's SRH • tailor counselling to the needs of the individual • use basic counselling techniques, including establishing rapport, active listening, demonstrating empathy, questioning and probing, summarizing and reflecting • provide appropriate counselling referrals when needed
3. Assess the effectiveness of counselling	Knowledge: • basic techniques of assessing user experience and satisfaction Skills – ability to: • use rapid-assessment techniques • follow-up clients after counselling

Competency 6: The primary health-care team member/s effectively assess the sexual and reproductive health needs of users of primary health-care services for treatment and referral when necessary	
Tasks	**Knowledge, skills**
1. Take an appropriate health history with a focus on factors related to SRH	Knowledge: • components of a health history • basic anatomy and physiology • SRH cycle and stages of reproductive development, and continuity of care • adolescent health and development, including sexual development • patterns of SRH-related morbidity in respective countries, and sexual and reproductive behaviour of communities • knowledge of sex and gender differences in health and during sickness • signs and symptoms of SRH pathology and problems (including HIV) • risk factors for unsafe sexual practices and their health risk • signs of violence, rape and gender-based violence (GBV) Skills – ability to: • establish rapport • communicate effectively including asking and responding to questions • demonstrate active listening • explore comprehensive SRH needs of client • effectively use appropriate job aids or checklist • identify signs of being “at risk” of danger • understand and assist victims of physical, emotional and sexual violence and abuse
2. Conduct a physical examination	Knowledge: • basic male and female anatomy and physiology • major congenital anomalies • physical examination procedures and objectives • steps in the examination of the female and male reproductive system • signs presented by women, children and men suffering from violence, GBV, rape • infection prevention and recommended infection-prevention practices

	Skills – ability to: • determine appropriate need for a chaperone • use the recommended infection-prevention practices to protect the individual, health-care provider and other health-care workers (hand-washing before and after contact with client, wearing gloves, etc.) • perform physical examination including inspection, palpation, percussion and auscultation • perform female pelvic and breast examination • perform male reproductive system examination – inclusive of the prostate
3. Ensure faster and safe referral	Knowledge: • the local referral systems and where to refer • referral guidelines for a particular clinical case or pathology • how to keep a patient safe during the referral process Skills – ability to: • follow the referral procedure • act fast and efficiently, particularly for an emergency referral • keep the patient safe during the referral process • refer upwards, horizontally or downwards as appropriate
4. Screen for male and female reproductive health preventable/or and treatable pathology	Knowledge: • reproductive tract pathology, inclusive of basic knowledge of reproductive tract cancers and their aetiology • screening principles for reproductive tract cancers • national guidelines and protocols for reproductive tract cancer prevention, screening and management • referral network for cancer

Competency 6 - continued

	Skills – ability to: • inform and counsel about preventive and curative measures • inform individuals about cervical cancer, its prevention and the treatment of precancerous cervical lesions • screen for preventable or treatable conditions (breast mass, cancer of the cervix and prostate) • perform routine care of the surgical instruments
5. Obtain or refer for appropriate laboratory tests related to SRH	Knowledge: • existing laboratory tests in use related to SRH (including HIV) • knowledge of the normal value for different tests' results • systems for referral in the community Skills – ability to: • interface across primary and secondary care for tests and referrals • conduct proper specimen collection, when appropriate • interpret test results • refer clients to the appropriate testing site • prepare referral requests upwards, horizontally or downwards, based on results

Domain 4: Specific clinical competencies	
Competency 7: The Primary health-care team member/s provide high-quality family-planning care	
Tasks as per Competencies 4–6, *plus*:	**Knowledge, skills as per Competencies 4–6, *plus*:**
1. Collect accurate family planning (FP) history	Knowledge: • how FP improves the health of women and their babies, and contributes to the reduction of maternal deaths, and perinatal morbidities and deaths • variety of available contraceptive methods • conditions that affect FP use (medical, social and individual circumstances), rumours and myths related to FP • gender norms and roles affecting the use of, and access to, FP services • gender issues regarding FP • community concerns regarding FP • local statistics and targets on FP use • signs and symptoms of GBV, rape, and vulnerable groups and their needs (GBV is high in couples with fertility problems) • connection between FP and environment, education, etc. Skills – ability to: • address myths • rule out pregnancy without a pregnancy test or knowing that the woman is having her period • deal with chronic conditions like HIV • apply Competency 5 to FP
2. Provide correct information on FP (birth spacing, contraception and infertility) to individuals, couples and groups	Knowledge: • basic understanding of human reproduction, infertility, fertility and fertility regulation • FP benefits, limitations, effectiveness, side-effects and health risks, etc. • variety of contraceptive methods • emergency contraception • FP care standards and protocols • The male and his responsibility/involvement in FP • FP as an issue for the couple

Continued

	• how contraceptive methods work: hormonal methods, postpartum and emergency contraception, lactational amenorrhoea method (LAM) and transitioning from LAM to other contraception, intrauterine device (IUD) and post-placental IUD insertion, etc. • the effectiveness of different methods compared with one another • contraceptive choices for adolescents • contraceptive choices for individuals living with HIV/acquired immunodeficiency syndrome (AIDS) • management of side-effects, method failure, complications • when to provide HIV post-exposure prophylaxis • when and where to refer any clients for special needs • where each FP method can be obtained Skills – ability to: • explore about past and current FP use, and future fertility plans • provide tailored and personalized information to help the client and her/his partner to make FP informed, voluntary decisions • explain method use
3. Assess the client for medical eligibility for FP, performing, where necessary and appropriate, physical examination and tests	Knowledge: • medical eligibility criteria for the use of FP methods Skills – ability to: • rule out if a woman is pregnant, in order to be able to provide contraception when desired • perform physical examination and history-taking to detect conditions that would contraindicate the use of contraceptive methods
4. Carry out FP procedures	Knowledge: • FP planning methods Skills – ability to: • demonstrate male and female condom use • fit cervical barrier methods • give injections • provide emergency contraception and HIV post-exposure prophylaxis • insert and remove IUDs, implants and other contraceptive devices

	• provide or refer for male and female sterilization services • discuss and explain the "standard days" method and other natural FP methods
5. Assess satisfaction with and correct use of method with return clients, helping dissatisfied clients or clients experiencing problems to switch to other methods	Knowledge: • interviewing and history-taking methods • side-effects and problems with use • follow-up needs • schedule of follow-up, resupply Skills – ability to: • interview and take history • reassure client about the method they chose • assist them in solving issues • help them in switching methods
6. Assess individual/couple for infertility and refer if needed	Knowledge: • concepts of infertility, causes and management (links to STI, reproductive tract infection (RTI) management, cervical screening, infectious diseases such as tuberculosis (TB), HIV, hepatitis B and C) • guidelines on when to refer if needed for evaluation, treatment, negative behaviour (i.e. smoking cessation, stress reduction) or to fertility support groups • sociocultural beliefs and practices that are either useful, neutral or harmful (i.e. unacceptability of men masturbating in order to obtain a semen sample, traditional healers to be consulted prior to modern medicine) • factors that could lead to infertility: nutrition/folic acid, age (sex differences), birth weight, smoking, relationship and other stress, over-the-counter and recreational drugs (alcohol), occupational hazards, scrotal injury or temperature (men) • laboratory procedures, e.g. simplified semen analysis (volume, pH, sperm count and motility), postcoital test or referral • fertility-awareness methods Skills – ability to: • provide couple-centred management • take a history for infertility (specific criteria) • administer a physical examination to identify for gross morphology of male or female genitalia • conduct preconception counselling on lifestyle: nutrition/folic acid, age (sex differences), birth weight, smoking, relationship and other stress, over-the-counter and recreational drugs (alcohol), occupational hazards, scrotal injury or temperature (men)

Competency 8: The primary health-care team member/s provide high-quality sexually transmitted infection and reproductive tract infection care

Tasks as per Competencies 4–6, plus:	Knowledge, skills as per Competencies 4–6, plus:
1. Collect an accurate history of past and present STI/RTI	Knowledge: • local perceptions around STIs/RTIs • factors influencing STI/RTI risk (behavioural factors, male circumcision, vaginal douching, etc.) • STI epidemiology at national and, when needed, at community level, and its links to HIV infection • diagnostic STI tests, HIV counselling and testing • management of post-sexual assault Skills – ability to: • conduct medical history of STIs/RTIs • elicit STI/RTI symptoms • handle survivors of sexual violence, sexual abuse and exploitation
2. Detection and management of STIs/ RTIs	Knowledge: • clinical presentations of STIs/RTIs and their sequelae • STI/RTI assessment during FP visits • STI/RTI assessment in pregnancy, childbirth and postpartum period • STI/RTI complications related to pregnancy, miscarriage, abortion • national guidelines and protocols for STI/RTI management • STI/RTI/HIV transmission and prevention • aetiologic and syndromic management of STIs/RTIs • HIV counselling and testing • patient and partner referral and treatment • case reporting Skills – ability to: • conduct physical examination to detect STIs/RTIs • collect sample for RTIs and STIs • perform tests using available diagnostic tools • use STI syndromic management flowcharts • offer and provide HIV counselling and testing • address partner referral

Competency 9: The primary health-care team member/s provide screening and treatment/referral for reproductive tract cancers	
Tasks as per Competencies 4–6, *plus*:	**Knowledge, skills as per Competencies 4–6, *plus*:**
1. Provide screening and treatment/ referral for cervical cancer	Knowledge: • signs and symptoms of cervical cancer • cervical cancer screening methods • procedures for testing • VIA (visual inspection with acetic acid) screens for cervical cancer, possible complications • management of precancerous lesions • Papanicolau (Pap) smear technique Skills – ability to: • perform VIA • manage precancerous lesions including using cryotherapy • perform cervical punch biopsy • perform Pap smears • refer for large lesion and suspicious of cancer
2. Provide human papillomavirus (HPV) vaccine; eligibility assessment, screening and administration	Knowledge: • HPV vaccine eligibility • national policy related to HPV • HPV calendar Skills – ability to: • administer HPV vaccine
3. Provide screening/referral for breast cancer	Knowledge: • breast cancer risk and protective factors • breast cancer signs and symptoms Skills – ability to: • perform clinical breast examination • teach breast self-examination
4. Provide screening/referral for prostate cancer	Knowledge: • symptoms and signs of prostate cancer Skills – ability to: • perform digital rectal examination

Competency 10: The primary health-care team member/s provide high-quality comprehensive abortion care

Tasks as per Competencies 4–6, *plus*:	Knowledge, skills as per Competencies 4–6, *plus*:
1. Management of abortion complications	Knowledge: • signs and symptoms of pregnancy • gestational age and its calculation • signs, symptoms, and management of spontaneous abortion, missed abortion, induced abortion and related complications • abortion management standards and guidelines • referral management for repeat spontaneous abortion and complications that are not treatable in loco Skills – ability to: • perform abdominal and vaginal examination to assess gestational age • perform abortion care by appropriate vacuum aspiration (VA) or dilatation and curettage if VA is not available • recognize complications of abortion • treat abortion complications • refer when needed
2. Inform and counsel on spontaneous abortion, unwanted pregnancy and induced abortion	Knowledge: • fertility return after abortion • symptoms and signs of abortion complications • risk factors for repeat spontaneous abortion • risks of unsafe abortion • legal grounds for induced abortion • pregnancy options for women and couples, including those who are HIV positive • barriers to safe, legal abortion and how to address them • medical eligibility for abortion methods • emergency contraception and HIV post-exposure prophylaxis • how, when and where to refer women Skills – ability to: • provide complete and easy-to-understand information about abortion and recurrent abortions, • refer the client to another provider in case of conscientious objection, or need for high-level care, or if abortion methods are not available • ability to refer for antenatal care (ANC) if the client decides to remain pregnant • ability to discuss SRH following abortion – i.e. contraception, STI screening

3. Provide, or refer for, induced abortion	Knowledge: • abortion law and its applicability (legal protection available to women and providers) • national norms, standards, and guidelines for abortion care, including rules for conscientious objection to provision of induced abortion • confirmation of pregnancy and determination of gestational age • medical eligibility for all available abortion methods • pain management, including verbal reassurance • appropriate referral for abortion after 12 weeks since last menstrual period Skills – ability to: • perform a bimanual uterine examination • perform VA and to provide medical abortion according to national standards, including appropriate pain management • manage abortion-related complications
4. Provide post-abortion contraception	Knowledge: • medical eligibility requirements for contraceptive methods • post-abortion FP methods • return to fertility post-abortion and safe time to get pregnant again • how and where to obtain contraceptives (preferably in the same place where they have had the abortion or post-abortion services) Skills – ability to: • provide contraceptive methods, including insertion of IUDs and implants, injectables, and emergency contraception immediately after abortion or post-abortion services have been performed • also refer to Competency 8 (STIs)
5. Provide or refer for other SRH needs	Knowledge: • signs and symptoms of RTIs • signs and symptoms of GBV • when and where to refer for appropriate follow-up care Skills – ability to: • provide syndromic management of RTIs

Competency 11: The primary health-care team member/s provide high-quality antenatal care	
Tasks as per Competencies 4 and 5, *plus*:	**Knowledge, skills as per Competencies 4 and 5, *plus*:**
1. Take a detailed obstetric history	Knowledge: • menstrual cycle, signs and symptoms of pregnancy and calculation of gestational age • components/elements of a thorough health history, family history and relevant genetic and obstetric history • psychological aspects and sociocultural beliefs and practices in pregnancy – useful, neutral and harmful • harmful effects on pregnancy – effect of smoking, alcohol use and illicit drug use on the pregnant woman and fetus • risk factors associated with pregnancy Skills – ability to: • be proficient taking a comprehensive obstetric history
2. Take a history of personal, family, environmental and socioeconomic circumstances	Knowledge: • power relationships in the family • the decision-makers in the family (e.g. mother-in-law or husband) • relevant care-seeking behaviours and what affect them (freedom of mobility, distance from the health service, finance, decision-making, etc.) • abilities to access ANC as often as needed and to seek timely emergency care Skills – ability to: • communicate appropriately to gather relevant information
3. Perform a physical examination including abdominal examination (fundal height, position, lie and descent of fetus) and assess fetal growth and well-being, and the adequacy of the pelvis	Knowledge: • female and male anatomy and physiology related to conception and reproduction • focused physical examination content for antenatal visits • normal progress of mother and baby during the antenatal period • gestational age by menstrual history, size of uterus and/or fundal height • fetal growth, development and well-being during pregnancy, including fetal heart rate and activity patterns • malaria in pregnancy and its consequences • prevention of mother-to-child HIV transmission (PMTCT)

	Skills – ability to: • conduct a thorough physical examination, abdominal examination, and pelvic examination, to assess fetal growth and well-being • identify variations from normality and institute appropriate interventions • calculate the estimated date of delivery. • monitor fetal heart rate using the available instrument • care for pregnant women living with HIV and chronic conditions • perform a pelvic examination determining the adequacy of the pelvis
4. Inform, educate and counsel about healthy habits, and provide guidance and basic education and preparation for labour, birth and parenting	Knowledge: • education needs regarding normal body changes during pregnancy, relief of common discomforts, hygiene, sexuality, nutrition, work inside and outside the home • immunization during pregnancy • nutritional requirements of the pregnant woman and fetus • anaemia prevention and control (iron and folic acid supplementation) • self-care education, birth preparedness and complication readiness for self and family and community, safe sexual practices, information on danger signs • health-education content targeted to ANC, including STIs, HIV/AIDS and child survival • vulnerable groups and their needs, including pregnant adolescents, single and poor women, people with disabilities • benefits and risk of different birth settings • preparation of the home/family for childbirth and the newborn baby • impact of drugs on pregnancy and the developing fetus Skills – ability to: • use health education and basic counselling appropriately • involve the husband/partner and the wider family in pregnancy care • advise on danger signs, emergency preparedness and follow-up, birth preparedness

Competency 11 - continued

5. Routine care to maximize the health of the mother and fetus during pregnancy	Knowledge: • ANC-related national policy • national ANC guidelines • protocols and screening practices including components such as: vaccinations, malaria IPT (intermittent preventive treatment), TB, PMTCT, deworming, vitamin A, syphilis, iron and folic acid, etc. • investigative laboratory tests that evaluate and assess pregnancy progress • routine screening practices for conditions such as anaemia, hypertension, syphilis, HIV Skills – ability to: • assess and provide support for normal pregnancy • record carefully and follow-up findings appropriately • order and/or perform and interpret common laboratory tests such as haematocrit, urinalysis or microscopy
6. Identify, manage/refer complicated pregnancies	Knowledge: • danger signs in pregnancy, e.g. pre-eclampsia, vaginal bleeding, premature labour, severe anaemia • pregnancy-related conditions requiring treatment, referral and/or transfer • signs, symptoms and indications for referral of selected complications and chronic conditions of pregnancy, e.g. asthma, HIV infection, diabetes, cardiac conditions, postdated pregnancy, and effects on mother and neonate Skills – ability to: • detect women presenting with risk factors • perform basic life-saving interventions • provide timely referral when needed

Competency 12: The primary health-care team member/s provide high-quality care during labour, birth and immediate postpartum

Tasks	Knowledge, skills
1. Provision of optimum maternal care during labour, delivery and the immediate postpartum period according to the individual circumstances and the local sociocultural context	Knowledge: • psychological and cultural aspects of labour, birth and the postpartum period • importance of emotional support in labour • comfort measures in labour, e.g. family presence/assistance, positioning • importance of provision of adequate hydration and nutrition during labour • cleanliness of woman and environment • PMTCT national programme Skills – ability to: • take a specific obstetric history • monitor maternal vital signs in labour • use national protocols in the case of diagnosis of abnormal labour patterns and complications, for management and/or referral • involve traditional birth attendants when present in the woman's psychological support group
2. Identification and monitoring of the maternal and fetal well-being during the progress of labour	Knowledge: • anatomy and physiology of labour • normal progress of labour and use of the partograph • anatomy of the fetal skull and pelvis, maternal and fetal critical diameters, and landmarks • process of fetal passage Skills – ability to: • perform abdominal assessment for fetal situation, position and descent • perform a pelvic examination to assess dilatation and effacement of the cervix, descent of the presenting part, status of the membranes and adequacy of the pelvis for the baby • assess the effectiveness of uterine contractions • monitor maternal and fetal vital signs and the progress of labour with a partograph • provide bladder care

Competency 12 - continued

3. Detection/treatment of problems and complications	Knowledge: • identification of abnormal labour patterns and timely interventions or referral • diagnosis complications (e.g. bleeding, labour arrest, malpresentation, pre-eclampsia, eclampsia, maternal and fetal distress, infection, prolapsed cord) • management/treatment of complications Skills – ability to: • perform emergency care during labour, according to national protocols
4. Referral of women with complications requiring a higher level of care, and provision of pre-referral management	Knowledge: • indications for operative delivery, e.g. fetal distress, cephalo-pelvic disproportion • pre-referral management Skills – ability to: • stabilize the woman and/or the fetus before referral • ensure the fastest and safest possible referral
5. Conduct of a clean and safe childbirth and placenta delivery	Knowledge: • importance of personal support from a person of the woman's choice • maternal and fetal physiology during childbirth • supportive care and pain relief • protocols of care for HIV-positive women • importance of cleanliness of woman and environment • indication of episiotomy • transition of neonate to extra-uterine life • management of third stage of labour Skills – ability to: • provide support during birth and assist the woman to give birth in the position she prefers • perform appropriate hand manoeuvres for cephalic and breech delivery • inspect the placenta and membranes • estimate maternal blood loss • inspect the perineum, vagina and cervix for lacerations and managing as per protocols • care for HIV-positive women and neonates • undertake, only if indicated, an episiotomy and repair

6. Identification, treatment, and management or stabilization prior to referral of abnormalities and complications of birth (e.g. bleeding, prolonged labour, vacuum extraction, breech presentation, episiotomy, repair of genital tears, manual removal of placenta)	Knowledge: • signs and symptoms in the mother or the neonate that call for immediate action or referral • principles of physiological management of the placenta/active management • neonatal asphyxia and its management Skills – ability to: • identify maternal problems (e.g. bleeding, prolonged labour, vacuum extraction, breech presentation, episiotomy, repair of genital tears, manual removal of placenta) • perform physiological and active management of the third stage (immediate oxytocin, controlled cord traction, uterine massage) • manage a cord around the baby's neck during delivery • manage antepartum and postpartum haemorrhage
7. Immediate care of the neonate	Knowledge: • essential neonatal care; basic needs of the neonate: breathing, warmth, feeding and protection • the importance of exclusive breastfeeding and of immediate postpartum breastfeeding • national protocols for relevant local conditions • knowledge of hepatitis B vaccine and BCG (bacillus Calmette–Guérin) • prophylaxis for ophthalmia neonatorum and the use of vitamin K Skills – ability to: • clamp and cut the cord • assess the immediate condition of the neonate • perform a screening physical examination of the neonate • ensure neonate is kept warmth, preferably by skin-to-skin contact with the mother • support the initiation of breastfeeding within the first hour of birth or as soon as possible after birth • care for neonates exposed to HIV • assist early attachment: mother–father–baby, where culturally acceptable • administer eye prophylaxis for ophthalmia neonatorum, and vitamin K as per national protocols • provide routine vaccinations agreed in-country

Competency 12 - continued

8. Management of neonatal complications	Knowledge: • common problems in the neonate • signs and symptoms in the neonate that call for immediate action or referral • low birth weight (LBW) management, including the kangaroo method • protocol and care for neonates of HIV-positive mothers • neonatal syphilis detection and treatment Skills – ability to: • identify problems in the neonate and manage when possible • apply the kangaroo method for LBW babies • involveme the husband/partner in neonatal care (e.g. kangaroo method)

Competency 13: The primary health-care team member/s provide comprehensive, high-quality, postnatal care for women and neonates

Tasks	Knowledge, skills
1. Assessment and care of the woman and of the neonate during the postnatal period (up to six weeks)	Knowledge: • normal postnatal progress of mother • signs of sub-involution, e.g. persistent uterine bleeding, infection • signs of breastfeeding problems • maternal nutrition, rest, activity and physiological needs/sexual life • care of HIV-positive women and neonates exposed to HIV • normal postnatal progress of the neonate • umbilical cord stump care • parent–infant bonding/physiological and emotional attachment • common problems in the neonate, referral and management Skills – ability to: • examine the fundus, lochia and perineum (tears, swelling, pus or bleeding) • manage postpartum complications • check the mother for HIV and syphilis as per national programme • in case of confirmed syphilis or HIV, manage in loco or refer as per protocols • make observations of the baby's health and behaviour • break bad news when required • support the family if the baby is stillborn, or there is neonatal or maternal death

2. Support of breastfeeding	Knowledge: • process of lactation and common variations including engorgement • infant nutritional needs and the benefit of breastfeeding Skills – ability to: • perform a breast examination • support the mother in the immediate postpartum period • assist with breastfeeding management and its problems • communicate with the mother and motivate her while giving instructions
3. Detection and management/referral of maternal and neonatal health problems and/or complications (e.g. fever, infection, bleeding, anaemia, LBW, etc.)	Knowledge: • postpartum complications • major neonatal problems • development of urinary and or faecal incontinence • detection and national management of HIV-positive and/or syphilis-positive women and their neonates • pre-referral treatment of maternal and neonatal complications (severe PPH, puerperal sepsis, cerebral damage, severe prematurity, etc.) • signs and symptoms of life-threatening conditions that need referral (e.g. persistent vaginal bleeding, urinary retention, postpartum pre-eclampsia, puerperal sepsis) • signs and symptoms of different levels of postnatal depression, e.g. “baby blues” the mildest, to postnatal depression, and postnatal psychosis the most severe • the management of post-natal depression • local support groups for mothers with less severe postnatal depression • referral systems for women with more severe depression or puerperal psychosis Skills – ability to: • detect and treat pre-eclampsia, eclampsia, anaemia, PPH, early postpartum infection, UTI, postpartum depression etc. • apply national protocols of treatment and care of detected STI (including HIV) • stabilize the woman and/or the neonate before referral • ensure fast and safe referral when necessary and possible • observe the mother’s emotional state, beginning in antenatal clinics and continuing throughout postpartum • facilitate the use of support networks • appropriately refer and follow up

Competency 13 - continued

4. Information and counselling on: self-care, danger signs, emergency preparedness and follow-up nutrition, safe sex, FP and prophylaxis in malaria areas	Knowledge: • concept of safe sex • malaria-prevention measures • in the case of HIV-positive woman, advise on PMTCT, including infant feeding, and eligibility for postpartum FP methods – any method, long term and permanent • information on LAM Skills – ability to: • discuss FP and contraception • provide/supply FP methods immediately at the site of delivery • advise on safe sex • advise prevention measures in malaria-endemic areas

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