Best Practices for Paraprofessional Capacity Building in Health

Evidence from resource-constrained contexts

Innovations for Poverty Action

EDUCATION

EVIDENCE BRIEF

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Summary

This document summarizes evidence-based best practices for developing sustainable capacity for health paraprofessionals—also known as lay health workers, community health workers, or non-specialist providers—in resource-constrained environments. Evidence indicates that the most effective way to build capacity in these settings is through a holistic, continuous model that focuses on the development of the specific knowledge and skills required for the job, including the ability to build trust, demonstrate empathy, and communicate effectively with program recipients. These elements can effectively be developed through the intervention design, training, and supervision to ensure paraprofessionals can deliver programs with quality.

KEY TAKEAWAYS

- Paraprofessionals can deliver high-quality services when interventions are simple and focused on core concepts, training is experiential, and supervision is supportive.
- Supervision is essential, but it doesn't have to be all in-person—a hybrid model combining periodic in-person visits with regular remote support can be effective when regular in-person supervision is not feasible.
- More research needs to be conducted about how to retain paraprofessionals, how much training is enough, and how to best combine digital and in-person support.

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Introduction

To address the gap between the number of people needing health and social services and the professionals available to provide them, the global health sectors is increasingly relying on task sharing. This involves shifting specific tasks from highly specialized professionals to paraprofessionals.

Paraprofessionals are often community members who do not have advanced degrees in the relevant field but receive targeted training to deliver essential services or programs. However, simply recruiting these individuals is not sufficient. To ensure that paraprofessionals can provide and sustain high-quality interventions, it is necessary to build their capacity.

Evidence-based Recommendations

EFFECTIVE INTERVENTIONS FOCUS ON SIMPLE PRINCIPLES AND CORE CONCEPTS

Research indicates that training for paraprofessionals should not aim to turn them into "mini-doctors" or "mini-psychologists" by teaching complex theories. Instead, successful training programs come with "wise interventions," which focus on simple principles and core concepts rather than complicated skills or pathologies. While the core of this evidence review was not centered on intervention design, it is important to note that complex interventions are often paired with the need for advanced skills (Osborn et al., 2021).

CASE STUDY

Effect of Shamiri Layperson-Provided Intervention vs. Study Skills Control Intervention for Depression and Anxiety Symptoms in Adolescents in Kenya: A Randomized Clinical Trial (Osborn et al., 2021)

The Challenge: In Kenya, adolescents face high rates of depression and anxiety, but there are few mental health professionals.

The Intervention: The Shamiri intervention recruited recent high school graduates as lay providers. They received a 10-hour training focused on simple, positive psychological concepts (growth mindset, gratitude, and value affirmation) rather than complex clinical therapy.

Results: Despite the training being brief and delivered by non-specialists, the intervention significantly reduced depression (post-intervention 0.35 standard deviations (SD), 2-week follow-up 0.28 SD, and 7-month follow-up 0.45 SD) and anxiety symptoms (post-intervention 0.37 SD, 2-week follow-up 0.26 SD, and 7-month follow-up 0.44 SD) in adolescents.

Takeaway: Training does not need to be lengthy to be effective. If the training and curriculum are simplified and targeted, lay providers can deliver high-level results.

TRAINING IS EFFECTIVE WHEN IT IS HANDS-ON, TARGETED, AND DESIGNED FOR THE REALITIES OF FRONTLINE WORK

Evidence points to four elements of training that improve knowledge, skills, and confidence and deliver effective interventions:

1. **Active Practice over Theory:** Training should minimize the use of slideshows and theoretical content while maximizing experiential learning opportunities. This includes:
   - **Role-Playing:** Practicing scenarios they will face in the field.
   - **Modeling:** Trainers demonstrating exactly how a task should be done.
   - **Competency Checks:** Paraprofessionals should not complete training simply by attending; they must demonstrate their skills through direct observation.
2. **Targeted and Simplified Content:** Training curricula must be tailored to the educational background of the learners. Content should be broken down into small, digestible components (referred to as "chunking"). This aligns closely with having "wise interventions." Training quality—not training volume—is a stronger predictor of competency outcomes, and programs that prioritize needs-based design over generic content show consistently better results (Liang et al., 2019).
3. **Effective Job Aids:** Given that memory can be unreliable, especially in high-stress situations, training must incorporate job aids—such as flip charts, pictorial guides, or decision-support apps—allowing paraprofessionals to access support in the field. This approach helps reduce cognitive load and ensures adherence to protocols.
4. **Promote Soft Skills:** Simply teaching technical skills or curriculum activities is insufficient for effective program delivery. Pooled evidence from non-specialist mental health interventions in LMICs shows a combined effect size of approximately 0.49 (Singla et al., 2017, as cited in Pedersen et al., 2020), comparable to specialist-delivered care, when foundational competencies are adequately trained. Training must explicitly cover soft skills like how to listen, validate feelings, and build rapport. When addressing mental health and psychosocial support (MHPSS), common skills developed in training include: promoting hope and realistic expectancy, explaining and assuring confidentiality, giving praise, psychoeducation, rapport building and self-disclosure, empathy, incorporating the client's coping mechanisms, and collaborative goal setting (Pedersen et al., 2020; Shahnazi, 2021).

CASE STUDY

The effect of training and supervision on primary health care workers' competence to deliver maternal depression inclusive health education in Ibadan, Nigeria: a quasi-experimental study (Adefolarin et al., 2021)

The Challenge: In Nigeria, maternal depression is a "hidden burden." While prevalence is high, few women seek help because primary health workers lack the competence to discuss the topic in a culturally appropriate way during routine health education.

The Intervention: The program implemented an apprentice model combining short-term training with follow-up supervision.

- *Training:* Workers attended a one-day intensive workshop. Instead of dry lectures, the training used active methods like role-playing, brainstorming, and the use of culturally specific songs and posters to address myths about depression.

- *Supervision:* Following the training, a specific group of workers received supportive supervision for one month (six visits). The supervision was explicitly designed based on WHO guidelines to remove "threat or intimidation." The supervisor's role was not to police the workers but to encourage teamwork and provide feedback in a safe environment, fostering motivation rather than fear.

Results: The training was effective for patients to seek help for depression. In the comparison group (no training), zero clients sought help for depression. In the training group, 40 clients sought help. It was the supervision that drove the results. Of the 40 clients who sought help, 35 came from clinics with supervised workers, whereas only 5 came from clinics where workers were trained but not supervised.

Takeaway: Training provides the skill, but supervision ensures the application. Without the confidence and motivation built through supportive supervision, health workers may possess the knowledge but fail to translate it into the patient interactions that drive real health-seeking behavior.

SUPERVISION IS ESSENTIAL TO ENSURING THAT TRAINING TRANSLATES INTO QUALITY SERVICE DELIVERY

If training is the engine that drives performance, supervision acts as the fuel that keeps it running. Literature identifies supervision as a primary bottleneck in implementation, but also essential for ensuring consistent quality (Shahmalak et al., 2019; Burnett et al., 2018).

Supervision is important for three main reasons. First, supervision helps paraprofessionals apply what they learned to complex, real-life situations. By doing so, supervision bridges the gap between knowing and doing—it accounts for the fact that real-world application is messy and that not all cases can be foreseen. Second, paraprofessionals operate with limited training. Continuous supervision ensures they are sticking to the protocol and managing high-risk cases safely.

Lastly, frontline work is emotionally draining, more so when paraprofessionals live under similar stressors as the program participants. Supervision can offer a safe psychological space where workers can process their emotions (Barnett et al., 2018).

Traditional supervision in many contexts is punitive, focused on inspection and finding faults. Best practices point to a shift toward supportive supervision. This type of supervision usually includes:

1. **Building trust:** Supervision should be a partnership, not a policing exercise. It requires a relationship built on trust, where the paraprofessional feels safe admitting mistakes.
2. **Providing Feedback:** Supervisors should not just check paperwork. They should observe the paraprofessional in action. Feedback should be supportive by publicly praising what they did right, and corrective by privately and gently correcting errors with a focus on improvement.
3. **Reflective Practice:** Supervision should extend beyond administrative tasks (e.g., "Did you file your reports?"). One way of doing so is by including reflective practice by posing questions like, "How did that client make you feel?" or "What challenges did you face in that interaction?" This process fosters emotional resilience and helps prevent burnout.

In resource-constrained settings, in-person supervision is often not feasible. In these situations, a hybrid model can be effective. This model incorporates occasional in-person visits to foster trust and allow for direct observation, along with regular remote support. High-frequency communication through instant messaging groups or phone calls can provide troubleshooting, boost morale, and facilitate peer support.

CASE STUDY

Digital Training for Non-Specialist Health Workers to Deliver a Brief Psychological Treatment for Depression in Primary Care in India: Findings from a Randomized Pilot Study (Muke et al., 2020)

The Challenge: In the rural Sehore district of India, the "care gap" for depression exceeds 90 percent. While non-specialist health workers (NSHWs) could bridge this gap, the traditional method of training them—residential, classroom-based workshops—is expensive and hard to scale.

The Intervention: The program piloted a "Digital Training" model to see if a smartphone app could replace classroom learning. They compared three groups:

1. *Face-to-Face (F2F):* Traditional 6-day classroom training.
2. *Digital (DGT):* Self-guided app-based training with reactive tech support only.
3. *Digital + Support (DGT+):* App-based training plus proactive remote supervision.

The DGT+ group supervision wasn't just about fixing technical glitches. It was proactive. A coach reviewed the learner's progress on a dashboard and made weekly phone calls to offer encouragement, praise progress, and answer content-related questions.

Results: The group with the app alone (DGT) had low completion rates (57 percent) and showed no significant improvement in competency scores. While the group with remote coaching (DGT+) had the highest completion rate (79 percent) and achieved competency gains comparable to the expensive Face-to-Face group.

Takeaway: Digital training was able to build real capacities when paired with human supervision, specifically proactive coaching, that kept learners motivated and supported.

Areas for Further Research

While the effectiveness of training and supervision is well-established, organizations must navigate several persistent "unknowns" within the literature. One significant challenge is attrition, where paraprofessional programs face turnover rates as high as 77 percent in certain contexts (Nkonki et al., 2011). Paraprofessionals frequently report feeling unsupported and undervalued—not just inadequately compensated—as a primary driver of dropout, and supervision emerges as the most modifiable protective factor (Kane et al., 2016). Despite this high turnover, there is a lack of definitive data regarding how to cost-effectively address this issue. Alternatives include, but are not limited to, creating incentives, whether financial, social recognition, or career pathing. However, it is unclear which intervention could be most cost-effective for retaining staff in the long term.

Additionally, the optimal dosage of training remains undefined; researchers do not yet know the "minimum effective dose" or whether a shorter model—such as 10 hours of training with weekly supervision—outperforms a 100-hour model with less frequent supervision. When defining the minimum viable intervention, determining this balance could be important. Finally, questions remain regarding digital efficacy: While digital training offers a cheap and scalable solution, early evidence from studies in India indicates that digital-only formats often fail to build competency unless accompanied by human coaching. Further research is required to determine the ideal blend of technology and human support.

Conclusion

As demand for health and education services grows in low-resource contexts, building capacity in paraprofessionals has become a critical strategy. To succeed, programs must move beyond "information dumping" via lectures. They must embrace experiential training that simplifies complex concepts, followed by supportive, reflective supervision that protects the mental well-being of the worker. With these elements, paraprofessionals can acquire the capacity to deliver programs effectively. At the same time, addressing remaining gaps in the evidence will be essential to scaling these programs sustainably.

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Methodology and Scope

This review screened approximately 70 papers identified through a targeted literature search using Google Scholar and consensus.app (with filters applied for RCT or quasi-experimental design, peer-reviewed publication in Q1 or Q2 journals, and studies from low- and middle-income countries). The search was supplemented by backward citation tracing—reviewing reference lists of included papers as well as training and supervision guidelines to identify additional relevant studies. Eligible papers required a primary study design of RCT or quasi-experimental, or qualitative studies describing training and supervision practices within experimental studies, and a peer-reviewed publication. Those studies were complemented with gray literature to triangulate practices and gather further detail on implementation. Each paper was coded across 20 variables covering study design, population, intervention characteristics, training and supervision practices, and outcomes. Of the papers screened, 42 met all inclusion criteria and were retained for analysis; 6 additional papers were flagged for geographic or methodological scope limitations (e.g., high-income country context) and were interpreted with caution. The review spans 19 low- and middle-income countries across the mental health and psychosocial support (MHPSS), community health, education, maternal and neonatal care, and infectious disease sectors.

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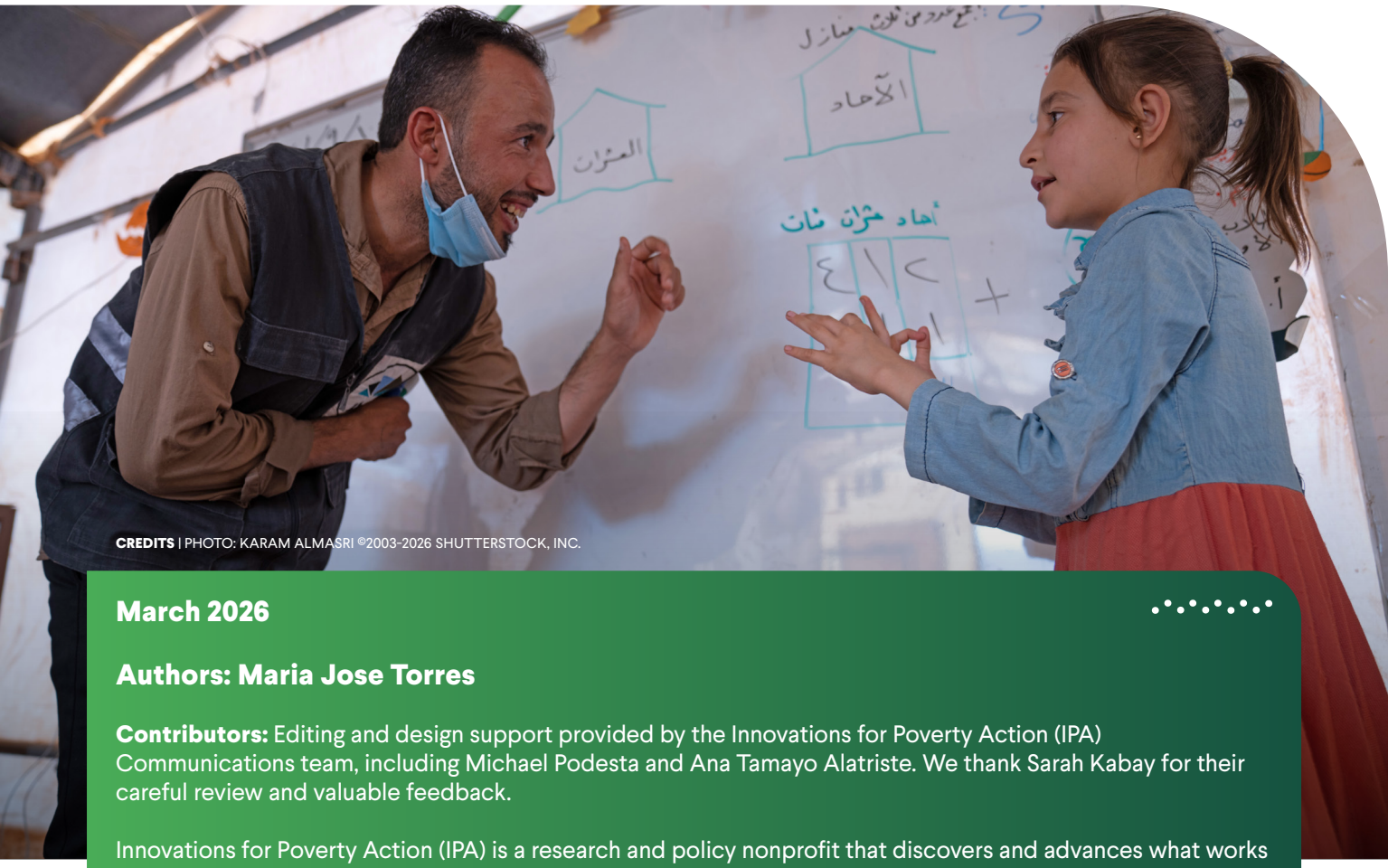

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