TECHNICAL REPORT

SOCIAL SERVICE WORKERS IN HEALTH FACILITIES:

Their Role in Addressing Social and Other Determinants of Health Among Children and Families

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CONTENTS

ABOUT THE GLOBAL SOCIAL SERVICE WORKFORCE ALLIANCE

Vision and mission

The Global Social Service Workforce Alliance, referred to as 'the Alliance', works towards a world in which a well-planned, developed and supported social service workforce engages people, structures and organizations to strengthen and build individual, child, family and community well-being and resilience.
Our mission is to promote and strengthen the social service workforce to provide services when and where they are most needed, alleviate poverty, challenge and reduce discrimination, promote social justice and human rights, and prevent and respond to violence and family separation. To achieve this, we work to build and channel the political will, actions, resources and structures necessary for a social service workforce that is knowledgeable, capable, critically reflective, resilient and committed.

History

The Alliance marked its official launch as a network in June 2013. The development of the Alliance is a direct result of participant feedback and expressed needs arising during a global conference held in 2010 to highlight the challenges facing the social service workforce and to explore strategies for addressing these challenges at a country and global level. The conference brought together teams from 18 countries to review this body of knowledge, share experiences and promising practices, and develop concrete action plans for strengthening the workforce. The Alliance was proposed to facilitate ongoing support and dialogue for strengthening the social service workforce.

Structure

The Alliance is an inclusive network of more than 3,100 individual members affiliated with a range of organizations and institutions across 148 countries. A globally representative Steering Committee, composed of 15 members, oversees and guides the direction and development of the Alliance, supported by a small secretariat. The Alliance is currently funded jointly by the U.S. Agency for International Development (USAID), under the Partnerships Plus project implemented by JSI Research & Training Institute, Inc., and by the United Nations Children's Fund (UNICEF) through projects at global, regional and national level. The Alliance is a fiscally sponsored project of Tides Center, a U.S. registered 501(c)(3) non-profit organization.

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ACRONYMS

APCCA	Advancing Protection and Care for Children in Adversity
EHR	Electronic Health Records
LMIC	Low- to middle-income countries
NICU	Neonatal Intensive Care Unit
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
USAID	U.S. Agency for International Development
USG-GSSW	United States Government's Global Social Services Workforce Working Group
UNICEF	United Nations Children's Fund
UNC	University of North Carolina
WCPU	Women and Child Protection Unit
WHO	World Health Organization

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EXECUTIVE SUMMARY

Social determinants of health—such as income, education, food and housing—have a substantial influence on individual health outcomes as well as on health inequities within and between countries (World Health Organization 2008). In fact, countries with greater total investment in health and social care spending compared to health spending alone have seen more positive health outcomes (Bradley et al. 2011; Davis 2015). The social service workforce plays a unique and powerful role in supporting individuals and communities in addressing social and other determinants of health. This role is characterized by application of a person-in-environment approach to assessing needs and facilitating access to needed services, promotion of social justice and human rights, and prevention and response to issues of behavioral and mental health, violence, abuse and neglect. With a social service workforce working in and linked to health facilities, there is much more potential for health systems to not only address clinical needs effectively and efficiently, but to tackle the inequities present in health care provision itself and to work towards more just, people-centered health systems and universal health coverage, in line with Sustainable Development Goal 3.

This paper aims to enable policy makers, civil society and advocacy groups to better articulate the value of the social service workforce in health systems through a presentation of the latest evidence on social service workforce roles, functions and promising practice models, and related influence on health outcomes and costs. Based on interviews, research and data from a range of countries, it outlines key challenges, opportunities and recommendations around effective and sustained deployment of the social service workforce when located in or linked to health facilities.

EXECUTIVE SUMMARY *(continued)*

The cross-cutting advantages or benefits of having social service workers deployed in health facilities are to enable a holistic approach to health care; address the social determinants of health; coordinate integrated care and support by working across sectors and disciplines; provide early identification and coordinated intervention in cases of violence against children, women or elders; and support patients across the life course. Social service workers in health facilities are best equipped to play the roles of behavioral health specialist, care manager, community engagement specialist and multi-level advocate. For health systems to gain the most from the unique skills and competencies of social service workers, care must be taken in determining how these workers are deployed. Models for deployment include the roving or liaison model, the permanent on-site support model and the interprofessional team model. To ensure the social service workforce is properly planned, developed and supported, the following recommendations are proposed:

- inter-ministerial leadership should work together to coordinate planning processes;
- adequate budget and other forms of resourcing must be factored into long-term planning for health facilities in which the social service workforce play a role;
- interprofessional learning opportunities should be cultivated within pre-service education, in-service training and continuing professional development for the social service workforce intending to or currently practicing in health settings;
- field placements (practicum) based in health facilities should be made available for all social service workforce cadre trainees;
- regular, supportive supervision for social service workforce in health settings is vital and should not be overlooked;
- regulatory and policy frameworks to support professional recognition of the social service workforce in health facilities and provide quality assurance should be developed.

INTRODUCTION

"The needs and risks of children, adolescents and families are multidimensional. Addressing a single issue in isolation leads to a fragmented approach. Children require integrated support, including through health care, nutrition, education, love, and protection."

— *Advancing Protection and Care for Children in Adversity (APCCA): A U.S. Government Strategy for International Assistance 2019-2023*

According to the World Health Organization (WHO), non-medical factors, such as income, education, food and housing, account for 30-55 per cent of health outcomes (World Health Organization n.d.). These factors, otherwise known as the social determinants of health, are the conditions into which people enter, live and exit their lives. They are acknowledged to have a substantial influence on health inequities seen within and between countries (World Health Organization 2008). In fact, more positive health outcomes are often seen among countries with greater total investment in health and social care spending compared to health spending alone (Bradley et al. 2011; Davis 2015).

The COVID-19 pandemic has emphasized inequities in health care access, treatment and outcomes across populations, particularly in low- to middle-income countries (LMIC) where fewer domestic resources are invested in health systems and where development assistance is often provided by donors. As countries embark on building back better, responding to social and other non-medical factors exacerbated by the pandemic will be fundamental for improving health and reducing inequities—and will require action by all sectors and civil society (Global Social Service Workforce Alliance 2020; Franceschini et al. 2021; Chen and Zhuang 2020; A. Ross et al. 2021a; Chigangaidze 2022; Prasad and Deshwal 2022).

The social service workforce plays a unique and powerful role in supporting individuals and communities in addressing social and other determinants of health. This role is characterized by application of a person-in-environment approach to assessing needs and facilitating access to needed services, promotion of social justice and human rights, and prevention and response to issues of behavioral and mental health, violence, abuse and neglect. This workforce constitutes a broad array of governmental and non-governmental practitioners, researchers, managers and educators, both professional and para professional. It includes but is not limited to social workers, social educators, social pedagogues, medical (health) social workers, child and youth care workers, community workers, welfare officers, social/cultural animators and case managers (Global Social Service Workforce Alliance n.d.). To enable countries to meaningfully tackle social and other determinants of health across the humanitarian and development spectrum and achieve universal health coverage[1], a well-developed and qualified social service workforce working in and linked to health facilities, holds much promise.

Departments and agencies across the United States Government are committed to identifying means of

[1] "Universal health coverage means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course." https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

strengthening the social service workforce and the systems in which they work, including the health sector. To this end, the United States Government's Advancing Protection and Care for Children in Adversity (APCCA) Secretariat has formed a sub-working group—the Global Social Services Workforce Working Group (USG-GSSW). One of the group's priorities is to "study, test and advocate for promising practice models for deployment of social service workers at health facilities."

The Global Social Service Workforce Alliance (the Alliance) is a network that promotes the knowledge and evidence, resources and tools, and political will and action needed to address key social service workforce challenges. The USG-GSSW has partnered with the Alliance to develop this technical report on the optimal role and functions of the social service workforce when located in or linked to health facilities, with the goal of highlighting promising practice models for planning, developing and supporting this workforce in different parts of the world, particularly LMIC.

This paper aims to enable policy makers, civil society and advocacy groups to better articulate the value of the social service workforce in health systems through a presentation of the latest evidence on social service workforce roles and functions in health facilities, and on promising practice models, and their influence on health outcomes and cost effectiveness. Based on interviews, research and data from a range of countries, it outlines key challenges, opportunities and recommendations around effective and sustained deployment of the social service workforce when located in or linked to health facilities. With this evidence in hand, it is hoped that advocates can make a compelling case for domestic resources or supplemental external funding to support and strengthen this workforce, ultimately resulting in better health for all.

BACKGROUND

Many countries have a long history of professional social workers, and other social service workers, engaged directly in hospital and community health settings. From the early 19th century in the United States and the United Kingdom, the earliest social workers, known as 'almoners,' worked in health facilities attempting to ameliorate the impoverished living conditions that contributed to patients' poor health (British Association of Social Workers n.d.). A similar, almoner-based model was introduced in 1952 in Nigeria, then a British colony, to address the rising numbers of patients unable to pay for health services, and although still not formally regulated, now continues via social work departments within federal government-owned health facilities (Okafor et al. 2017a). Other countries, especially those dealing with a legacy of colonialism, like Pakistan and the Philippines, followed a similar timeline, creating social work positions within hospitals or mental health institutions (Sajid, Alvi, and Nawaz 2021a; Price Kepa Artaraz 2013). In response to economic and political changes affecting patients' ability to afford care around the 1990s, Romania, Saudi Arabia and Zimbabwe increased hiring social workers in medical settings. However, this comparatively new workforce continues to face challenges in demonstrating its value and maintaining its role in these settings (Ciocănel et al. 2018a; Albrithen and Yalli 2015; Chitereka 2010a).

A concerted push toward person-centered, integrated care is being made at the global level by the WHO and other key donors in health and social service system development, including the United Nations Children's Fund (UNICEF) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (World Health Organization 2022a; 2022b; UNICEF 2021; 2019; PEPFAR 2022; 2020). Person-centered care is a reorientation to health care, in which health systems are designed around the needs of the individuals, families and communities that they serve. A culture of

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care coordination and communication is paramount to this person-centered approach, cultivated by informing and involving users in decision making around their own health. This approach is also aimed at making sure that services are affordable, accessible, safe, ethical, effective, evidence-based and holistic (World Health Organization 2013; PEPFAR 2020). Integrated care refers to bringing together multiple services, most notably physical, behavioral and mental health, so that people receive preventative to curative care according to their needs over time (World Health Organization 2018; Fraser et al. 2018b; Stanhope et al. 2015a). However, in LMIC with more external donor-supported health programming, integrated care has been understood and implemented differently, often bringing together different disease- or health-specific programming (e.g., HIV prevention and treatment within family planning services) rather than combining health and social care (Mounier-Jack, Mayhew, and Mays 2017).

A host of other high-income countries, such as Canada, the United Kingdom, Australia, Scotland and New Zealand, have reflected this trend toward integrated care with the release of joint health and social care workforce strategies, advocacy efforts and studies of the benefits of integrating the social service workforce into health care for a range of populations and practice settings (Bryson and Bosma 2018; Miller, Glasby, and Dickinson 2021; Scottish Government and COSLA 2022; Kirschbaum 2017a; Osborne et al. 2018a; Döbl, Huggard, and Beddoe 2015a; Hopia and Hakala 2015). Amidst mounting evidence in favor of such integration, the WHO estimates the health and social care workforces to reach 350 million by 2030 (Global Social Service Workforce Alliance 2022). Today, a vast majority of United States hospitals have a dedicated social work unit and the U.S. Department of Labor estimates there are 173,860 health care social workers (US Bureau of Labor Statistics 2022; Sajid, Alvi, and Nawaz 2021a). Nearly 35,400 additional social workers will be needed in the United States health system by 2026 as the trend toward more person-centered care continues, encapsulated under the Patient Protection and Affordable Care Act of 2010 (Fraser et al. 2018b; US Bureau of Labor Statistics 2022).

As of the latest available data, there are less than 2,000 social workers in hospitals serving a population of 200 million people in Nigeria, 260 social workers in state-run hospitals serving a population of 35 million in Saudi Arabia, and only 21 per cent of primary health care centers employ a social worker in South Africa (Kayode Ogedengbe, interview by author, 18 May 2022; Albrithen and Yalli 2015; Petersen 2021). These numbers demonstrate unfulfilled potential for workforce development to respond to unmet needs for social services, ultimately contributing to universal health coverage and progress on Sustainable Development Goal 3.[2] They also underscore a gap to be filled in synthesizing promising practice models to optimizing the current social service workforce, retaining them and training the next generation of social service workers as these cadres continue to advocate for their value and contributions in health settings. As stated by Allen (2012), "patient health doesn't begin and end in a clinic; rather, individuals live within families and communities that present them with unique challenges and resources."

By nature of their specialized education, professional values of social justice and human rights, and grounding in a person-in-environment approach, social workers and those related cadres within the broader social service workforce are singularly well-prepared to support these trends of person-centered, integrated health and social care (International Federation of Social Workers n.d.; A. M. Ross and de Saxe Zerden 2020a). How to operationalize what is known about the potential of the social service workforce to improve health outcomes, particularly for children and families dealing with chronic illnesses like HIV/AIDS, violence or mental health issues, in addition to more intransigent problems of poverty, inequality and marginalization, and limited infrastructure in LMIC remains less clear. **It is the intention of this technical report to distill evidence from literature and insights from experts to inform policy makers, program designers, and managers as they seek to improve health and social outcomes using an integrated approach for the populations with whom they work in LMIC.**

[2] United Nations Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages

METHODOLOGY

Scoping review

This technical report is a product of desk research carried out from March to July 2022 through two phases of inquiry. The first phase included a scoping review of published literature through search in the following databases: Google Scholar, PubMed, Scopus, and Web of Science. Gray literature materials were identified through the Global Social Service Workforce Alliance Resource Library, U.S. Centers for Disease Control and Prevention (CDC) Promising Practices Database, PEPFAR Solutions Platform, U.S. Agency for International Development's (USAID) Development Experience Clearinghouse, UNICEF headquarters and country office websites, and Google search. Relevant journals such as *Social Work in Health Care, Social Work Education, Interprofessional Care, Preventative Medicine, Lancet, Research on Social Work Practice, Global Health Action, Social Work in Mental Health, Child and Adolescent Social Work* and other peer-reviewed journals were explored.

Using wide parameters of search terms (including social work in health care/facilities, social worker roles and functions, social worker training in health, maternal and child health, integrated health care, behavioral health, costs, cost savings, cost benefits of social work in health), over 180 articles and materials in English language were identified and reviewed, with 65 peer-reviewed articles and 18 gray literature materials retained. The review covered January 2000 to May 2022, capturing evidence and promising practices on the role of social service workers in health care settings or health facilities in high-, middle- and low-income countries with a focus on children, adolescents, women and families in vulnerable situations.

This scoping exercise does not represent a systematic literature review and is not exhaustive. Health and behavioral health social workers account for more than 70 per cent of the whole social service workforce in the U.S., generating a high volume of publications on the inclusion of these workers in health settings (Stanhope et al. 2015a; NASW 2016a). This reality is evident in the scoping of the literature summarized in Table 1 below.

Table 1. Summary of the literature scoping exercise

Region	Global	North America	Latin America and the Caribbean	Western Europe	Eastern Europe and Central Asia	Middle East and North Africa	Sub-Saharan Africa	South Asia	East Asia and Pacific
Number of resources	10	47	0	3	6	1	10	3	3
Population / health setting	General	Children / adolescents	COVID-19	Community-based care	Emergency	Hospital	Primary care	Maternal and child health	Multiple
Number of Resources	63	20	3	5	2	6	17	8	42

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Key informant interviews

During the second phase of inquiry, a key informant interview guide with 15 open-ended questions was developed. Through confidential semi-structured interviews, 17 experts and program implementers representing national governments, academia, professional associations, multilateral and bilateral donors (such as the WHO, UNICEF and USAID), and development organizations from different regions were invited to share their experiences on introducing or integrating social service workers into health care facilities and settings. Participants were asked broadly about their knowledge and experience on the role of the social service workforce in health care settings; models or approaches to recruiting, deploying, managing and funding the social service workforce in health facilities; challenges faced by the social service workforce in health facilities; training/education and supervision requirements for the social service workforce in these settings; and the costs, benefits and savings related to integrating the social service workforce into health care teams and facilities. The findings were analyzed by the research team and major themes were identified for each of the interview questions.

FINDINGS

Types of social service workers in health settings

In settings where social work is an emerging profession, there is typically little recognition of the added value of incorporating a social service worker within a health care team or dedicated unit in a health facility. In addition, there is often a shortage of trained, professional social service workers to recruit to such posts. As a result, facilities seeking to address social factors affecting the health of their patients may invoke support from two sources of workers: 1) para professional or volunteer social service workers from the surrounding community, and/or 2) existing health worker cadres. Para professionals or volunteers—either recruited directly by the facility or via a community-based organization—can take on positions of case or care worker; social service assistant, aide or navigator; or a variety of home visitor, peer educator, counselor or mentor positions. Workers drawn from a country's existing health cadres to address social and other factors affecting a patient's health are usually nurses, as the importance of social determinants of health is increasingly reflected in nursing pre-service education (at least more so than physician training, but not at

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Two scenarios influencing deployment of social service workforce in health facilities

Research for this paper revealed two scenarios among LMIC that seemed to influence the deployment of the social service workforce in health facilities. These two scenarios, which did not appear tied to a country's economic status, are contexts where:

1. **social work is a new or nascent discipline, still in the process of professionalization;[3] or**
2. **social work is an established and mostly well-known discipline but still defining its place within health care.[4]**

Where appropriate, these scenarios are used to help organize findings around worker types; optimal worker roles and functions; and models for deployment, training, management, and supervision. These scenarios can assist countries in determining which of the practices described would not only be most applicable but would most likely result in a "workforce for health", inclusive of the social service workforce, that is best positioned to provide more holistic care and have a greater impact on health and other socio-economic outcomes and costs.

[3] Such contexts may by described by a lack of or limited regulatory or normative framework, little to no enforceable requirements around licensing, registration or certification, lack of or under resourced professional association or council.

[4] Such contexts may be described as having legislation on social work or social service professionals is in a final stage of development or is in place, covering the scope of practice and professional ethics/values, requirements on minimum education and training, licensing and registration, supported by a functioning professional association or council that may also perform a regulatory role.

the same scale as social work training) (Babayeva et al. 2018; UNICEF and Columbia School of Social Work 2019; Stanhope et al. 2015b; K. Browne, Chou, and Whitfield 2012).

Para professionals and existing health worker cadres typically receive specialized short-course or in-service training as part of a government- or donor-supported program focused on a specific health priority. For example, they can be trained to perform risk assessments for HIV, mental health or gender-based violence screening, and later be involved in high-risk women's and children's health and other home visiting programs (Thurman et al. 2016; Kidman et al. 2014a). In some scenarios, these workers are supervised by a professional, degree-holding social worker, in others, by facility or program staff as a means of reinforcing knowledge and skills from their training (FHI 360 2022; HRH2030 2021; Stanhope et al. 2015a; National Academies of Sciences 2019; Thurman, Kidman, and Taylor 2015a).

However, with patients facing numerous social and economic challenges, the barriers to care can be difficult to overcome with a para professional or "repurposed" health worker alone and may require a more specialized approach or more intensive, longer-term follow-up. Such support is ideally provided by a dedicated social work unit or social worker integrated into a health care team or co-located in the health facility. This type of worker brings a deep knowledge of available social service resources, strong ties to the facility and the community, and is prepared to advocate on behalf of the patient, family and community to improve social conditions overall (Ciocănel et al. 2018b; Döbl, Huggard, and Beddoe 2015b; Chitereka 2010b; Allen 2012; S. Craig et al. 2016; Hoeft et al. 2021). In most cases, social workers have the legal mandate, sufficient training, and code of ethics and minimum practice standards to guide their interactions with individuals, families and communities, including in people's homes, as part of their work to address the social and environmental context and factors that affect health (Rowe et al. 2017a; Döbl, Huggard, and Beddoe 2015c; Glaser and Suter 2016a; A. M. Ross and de Saxe Zerden 2020b; A. Ross et al. 2021b). Yet where the profession is new or struggling for broader recognition, recruitment of social workers in health facilities is generally not prioritized. It is also often challenged by worker shortages, budget allocations for such roles in facilities are rare or limited, and other less-costly or already-funded workers must be relied on instead (Chitereka 2010b; Dako-Gyeke, Boateng, and Mills 2018a; Okafor et al. 2017b).

In settings where social work is becoming more established as a profession, but still gaining ground in health facilities—such as in Nigeria, the Philippines and Romania—it is much more likely to find social service workers assigned to a social work unit, or in limited or solo social work duty stations within a hospital (Dako-Gyeke, Boateng, and Mills 2018a). They typically hold degrees or diplomas in social work and have completed a field placement or practical training in a health setting. Many are considered medical or hospital

Defining the social service workforce

The social service workforce is "an inclusive concept referring to a broad range of governmental and nongovernmental professionals and para professionals who work with children, youth, adults, older persons, families and communities to ensure healthy development and well-being" (Global Social Service Workforce Alliance n.d.). The exact job titles used for the social service workforce in health settings vary across different countries, in accordance with the historical development of the social service workforce, licensing and practice regulations in place, relevant policies, and other linguistic and cultural factors at play.

For the purposes of this technical report, the social service workforce includes professionals and para professionals working in or linked to health facilities and excludes community health workers and other lay cadres who have not received social service-specific training and are not performing primarily social service roles or functions.

social workers and are represented by a specialized professional association, which in some cases also oversees licensing or certification requirements specific to hospital-based practice.[5] Indeed, this trend towards specialization holds true not only in the higher-level training of these workers, but also in terms of their titles (e.g., medical social worker, care coordinator, patient navigator). It is thought that more specialist titles help to promote role clarity and better delineate their scope of practice within the health care delivery team and setting (National Academies of Sciences 2019).There may even be specialization related to their certification or licensure requirements, specific standards of practice and continuing professional education (NASW 2016a; SACSSP n.d.). Even in countries where social work is well established in health settings, a next-level specialization effort is underway in relation to these workers' capacity to bill for their services, either through government-supported insurance or through wage equity adjustments or stipulated budget lines for social workers engaged via the government/civil service in universal healthcare settings (National Academies of Sciences 2019; Stanhope et al. 2015a).

Independent of whether social workers or para social workers are engaged by health facilities in settings where social work is a new discipline or in settings where it is an established discipline, they contribute a strengths-based, human-rights driven, person-in-environment perspective to assessing patients' needs. Depending on their level of education or training, they can attend to the mental health of patients, through basic psychosocial support or more advanced individual or group therapies and counseling, services which are often limited in most health facilities in LMIC and for which other health workers are not trained or do not have time to provide. They also bring a deep understanding of the available resources at all levels and are experienced and ready advocates for the patient and their families. With the right social service workers deployed in a contextually appropriate and evidence-informed way, there is much more potential for health systems to not only address clinical needs effectively and efficiently, but to tackle the inequities present in health care provision itself and to work towards more just, people-centered health systems and universal health coverage, in line with Sustainable Development Goal 3.

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[5] Examples of specialized professional associations include the Association of Medical Social Workers of Nigeria (AMSWON), the Rwanda Allied Health Professions Council (which includes medical social workers), and the Mongolia Association of Health Social Work.

Overarching advantages or benefits of having social service workers in health facilities

Cross-cutting advantages or benefits of having social service workers deployed in health facilities include:

- **Enabling a holistic approach to health care:** The involvement of the social service workforce in health facilities can expand the traditional medical model, which focuses on diagnosing and treating disease with medical interventions, with a recognition of and support for the social and other factors that enable more effective and lasting treatment. Incorporating this "social work" lens can result in increased access to advice and support to make changes in certain at-risk populations' behaviour, social situation and environment, resulting in reduced hospital readmission rates, reduced length of patient stays in hospital, and reduced costs for health providers and/or patients.
- **Addressing the social determinants of health:** A significant proportion of the underlying factors contributing to poor health are social and behavioral, as much as physiological. In identifying, preventing and ameliorating these factors—including poverty, social exclusion, poor nutrition and housing, hazardous living conditions, abuse and violence—the social service workforce can play a key role in preventing or reducing illness and a range of health conditions. The preventive role can involve primary prevention (preventing initial onset of health conditions in the whole population) as well as secondary prevention (preventing or reducing ill health amongst the most at-risk populations or preventing its recurrence) (Andrews et al. 2015; Stanhope et al. 2015).
- **Coordinating integrated care and support by working across sectors and disciplines:** The social service workforce is trained and ideally placed to assess, plan and coordinate complex packages of care and support. This care may involve input from medical practitioners and therapists, the support of community volunteers and civil society groups, and coordination with local social welfare departments, early childhood services and schools, labor services, housing departments and police.
- **Early identification and coordinated intervention in cases of violence against children, women or elders:** Deployment in health settings can enable social workers with statutory child protection roles, as well as those involved in the assessment and intervention in cases of intimate partner violence, sexual violence and elder abuse, an opportunity for early identification of risk factors and signs of abuse as presented in injuries, behavior or concerns expressed by patients or their family member on admission to hospital or when arriving for emergency treatment. Once risks and concerns are identified, social workers in health settings are well placed to carry out multi-disciplinary assessment, and lead coordination with police and other statutory colleagues in child protection agencies, in the process of holding multidisciplinary case conferences, planning joint interventions and carrying out multi-agency reviews of such cases (UNICEF ECARO 2018).
- **Supporting patients across the life course:** Since the role of social workers, supported by the wider social service workforce, is to help support people through all the major challenges and transitions they face in life, their deployment alongside health colleagues enables them to provide timely and tailored support to patients, to help them navigate these life challenges and transitions. Prominent examples include supporting older people to return home through organising the care and support they need following a fall or stroke and supporting the most vulnerable mothers and their infants—including adolescents, those without the support of a partner or family, or those experiencing intimate partner violence—through pregnancy, childbirth and early childhood.

Models for deployment

For health systems to gain the most from the unique skills and competencies of social service workers—and produce the desired effects on health outcomes, cost effectiveness and overall quality of life for patients—care must be taken in determining how these workers are deployed. Depending on the structure of the health system and its maturity, the dynamics of the labor market and available workforce, and in line with the most pressing health and other socioeconomic needs of the population, some models may be more feasible than others. From permanent, on-site support, to working as part of a multidisciplinary or interprofessional team, or as a roving or community-based liaison, it is important that whatever model is employed ensures proximity of workers to the individuals they serve. This closeness enables trust and a relationship to be built as they delve into sensitive physical and behavioral health issues, alongside non-medical concerns that could be affecting care (Feryn, de Corte, and Roose 2021; Monterio et al. 2016a).

Roving or liaison model

In some settings, like a small clinic with limited private space for such relationship-building interactions to take place, a roving or liaison model with substantial time spent doing home visits may be the most appropriate. This model is often implemented in lower-resource settings or where integration of social services into health is developing. It has also been applied with support from donors seeking to strengthen linkages between clinics and communities within an existing health system but without making significant changes to staffing or infrastructure, often relying on memoranda of understanding or other collaborative agreements to clarify roles and responsibilities of the clinical and community partners (see PEPFAR case study box). This model has the advantage of combining both facility- and community-based health and social service interventions, which has been linked to positive health outcomes among women and children—such as reduced maternal mortality and increased birth weight, more symptom-free days for children with asthma, and increased use of contraception and fewer births among adolescent mothers (Steketee, Ross, and Wachman 2017a; Taylor et al. 2016a).

CASE STUDY:
Bringing together clinical and community partners for better health outcomes through PEPFAR

Since its inception in 2003, PEPFAR has invested over $100 billion in HIV/AIDS response worldwide, saving millions of lives and providing critical support to children, adolescents and their families. In its 2022 country operational plan guidance, PEPFAR recognizes that those it serves are more than clients with HIV, but rather "people who make their own decisions and deserve to have their rights and preferences respected with differentiated services adapted to their life course and social context." People-centered care has long been practiced within PEPFAR's Orphans and Vulnerable Children (OVC) programming. With an emphasis on wraparound services and close collaboration with partners operating in health facilities, PEPFAR OVC implementing partners have shown promising results integrating health and social services, and the workforces providing them, particularly using the roving/community liaison model.

In Eswatini, the Insika Project, led by Pact, leveraged existing cadres of home visitors already engaged in comprehensive case management for OVC to disseminate information on the COVID-19 vaccination, then liaise with vaccine mobilizers to register and follow up with children and caregivers over the two-dose series. Administered either at home by a visiting nurse or at a community site, 74 per cent of project beneficiaries offered the vaccine have now been vaccinated compared to 60 per cent of non-project beneficiaries in the same geographic areas. The highest-performing areas are

Case study continued on next page >

CASE STUDY: *continued*

where vaccine mobilizers are paired with nurses in roving teams. This success is attributed to stronger relationships, regular engagement, and the resulting rapport and trust between project beneficiaries and the home visitor connecting them to the health facility, creating increased demand for vaccines (Storer 2022).

In Zambia, the Empowered Children and Adolescent Program 1, led by the Center for Infectious Disease Research in Zambia, and the SAFE Project, led by John Snow, Inc., developed an intensified approach to community viral load sample collection. Community case workers identify young people who have missed or are having difficulties making their appointments as part of their routine case management home visits. The community case workers are paired with facility case workers who verify the patients' viral load status and facilitate access to testing provided on the weekends in nearby sites. This schedule is often preferred by adolescents who are either in school or uncomfortable waiting in long lines at health facilities. Viral load coverage at Nchanga North Referral Hospital, in the catchment area where this intensified approach has been deployed, has improved from 72 per cent in January 2021 to 97 per cent in March 2022 (USAID, PEPFAR, and CMMB. n.d.)

In Zimbabwe, the Catholic Relief Services-led Pathways Project, in conjunction with the Ministry of Health and Child Care, trained 86 workers classified as "points of contact" from among para professional social service cadres, like lead childcare workers, and stationed them at health facilities.

"Traditionally, in health facilities and for clinical workers, there has not been much space for social worker contributions…Slowly and progressively, we see some appreciation and acknowledgement of their role…People are beginning to find each other and appreciate that nobody is coming to intrude in each other's space but to complement each other," observed Richard Savo, Deputy Chief of Party for the project.

With agreements in place between the clinical and OVC implementing partners, and using a case management approach, these points of contact help children and families affected by HIV navigate needed services. They track them at the household level and monitor their risk of dropping out of treatment through close coordination with village health workers and community and childcare workers engaged by local implementing partners in nine districts. During COVID-19 shutdowns, the points of contact ensured multi-month supplies of medications were dispensed to HIV-positive patients to support adherence to treatment while regular health services were disrupted. Overall, the project has achieved a success rate of 95 per cent of HIV positive people who previously stopped taking their medication return to care (Catholic Relief Services 2022; Catholic Relief Services n.d.)

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Permanent on-site support

Where medical social work is established, and governments have, to some extent, created requirements for social work units or posts within public hospitals or other health settings, **permanent on-site support** is more prevalent. Co-location allows for these workers to be incorporated into existing clinic flows, such as intake or discharge, and contribute to a shared 'culture' within the facility. A review of seven studies of such social work interventions in primary care settings in the United Kingdom, the United States and Israel found increased resource access and lower psychological distress among patients with complex needs, reduction in depression and pain scores, and for a subset of HIV-infected male patients with depression, reduction in transmission risk behaviors (McGregor, Mercer, and Harris 2018).

Interprofessional team model

A different model—but one associated with a wide range of positive outcomes and in line with person-centered, integrated care—is the **interprofessional team model.** Based itself on the chronic and collaborative care models, the interprofessional team model revolves around the patient and his or her active role in decision making. It reflects the reality that to adequately address a patient's presenting medical issue, other non-medical issues must be responded to by a variety of disciplines working together toward a common goal. At a minimum, interprofessional teams consist of 1) a medical provider, 2) a care manager (usually a social service worker) and 3) a consulting psychiatrist or other behavioral health specialist, if available. Interprofessional teams in some settings have expanded to include staff from outside of the health facility, such as lawyers, to respond more comprehensively to a patients' environmental needs (Fraser et al. 2018a; National Academies of Sciences Engineering and Medicine 2019). These teams can operate within a health facility, or out of a community center, such as a city hall or school, if they are expected to provide home- or community-based follow-up care, provided there is a strong referral system in place between the team and the health facility (UNICEF 2021b).

Factors contributing to successful formation and collaborative work of interprofessional teams include: a defined scope for the team itself, clear and meaningful roles among the varied practitioners, guidelines or standard operating procedures for decision making, and tools to minimize gaps in or duplication of services (National Academies of Sciences Engineering and Medicine 2019; Kirschbaum 2017b; Tadic et al., n.d.). Bringing together team members across all the disciplines involved, known as interprofessional education or training, is the main means of ensuring that these elements for success are in place. A deeper dive into the recommended components of interprofessional training can be found in the section on models for training, management and supervision below. Learning side-by-side cultivates appreciation of others' specific skills and competencies, distinct professional perspectives, and unique contribution to improving outcomes for the patient (NASW 2016b; National Academies of Sciences Engineering and Medicine 2019; Fraser et al. 2018a; Glaser and Suter 2016a).

In addition to interprofessional training, technology is a critical tool for successful collaboration within these teams. Use of cell phones and texting among colleagues, telehealth platforms for virtual clinic and home visits, call centers for referrals, and data sharing and tracking via secure patient registries and Electronic Health Records (EHR), have been shown to assist in care coordination and teamwork among these varied professionals (National Academies of Sciences Engineering and Medicine 2019; Hoeft et al. 2021; Rowe et al. 2017a). Where in use, EHR provide a valuable source of information on which member of the team is screening for non-medical factors (such as housing stability, food insecurity and transportation), who is responding to those needs, and what the outcomes of such interventions have been (Richman et al. 2022). It can assist in reinforcing similar messaging to patients across the care team as well reduce or eliminate duplicative assessments of patients. Although less commonplace in LMIC and lower-level facilities, implementation of EHR is increasing in sub-Saharan Africa, South America, and other geographies, often driven by HIV programming, with open-source

software leading the way (Akanbi et al. 2012; Aminpour, Sadoughi, and Ahamdi 2014; Odekunle, Odekunle, and Shankar 2017). As the use of EHR and other technology increases in LMIC, planning efforts should prepare to overcome common challenges of interoperability and data protection across the health and social service sectors (National Academies of Sciences Engineering and Medicine 2019; Richman et al. 2022).

Communication, either in person or enabled by technology, is a core element to ensuring that all team members have the latest information on a patient's status, that an issue has not been missed or efforts duplicated, and that all agree with the assessed needs, interventions and plan for discharge (Glaser and Suter 2016a; Döbl, Huggard, and Beddoe 2015c). It is also most often facilitated by the social service worker on the team. Other means of ensuring that these factors are addressed by the team include case conferencing (where team members meet on a routine basis to review patients' care plans), joint meetings with patients and bi-directional referrals (Glaser and Suter 2016a; USAID 2022).

Studies of interprofessional teams containing a social worker have shown improvements in health outcomes in settings ranging from primary health care to emergency departments. In a systematic review of 26 randomized controlled trials, patients receiving integrated primary care provided by interprofessional teams involving social workers were more likely to have fewer symptoms of depression and anxiety at the end of treatment compared to routine services; had significantly fewer emergency room visits, hospital admissions or shorter lengths of stay; and were more likely to use an appropriate, lower cost level of care, such as a clinic (Fraser et al. 2018a). Another review of international studies showed associations between use of an interdisciplinary team involving a social worker with reduced neonatal intensive care unit (NICU) admissions and improved birth weight and infant functioning compared to controls (Steketee, Ross, and Wachman 2017b).

CASE STUDY[6]:

Interprofessional teams respond to violence against women and children in health facilities in the Philippines

Across the Philippines, there are over 115 Women and Child Protection Units (WCPUs) located in hospitals. With staffing comprised of doctors, social workers and law enforcement officers, these units deliver multidisciplinary, outpatient services with a focus on preventing and responding to all forms of abuse and violence against children and women. Team members are co-located and are trained jointly on how to screen for, intervene in, and manage cases of violence against women and children. In a few districts, where there are no WCPUs, there is loose collaboration between doctors and social workers on child protection issues. Funding for these units comes from the Philippine Government's Gender and Development budget, which ensures their sustainability.

These units have played a significant role in strengthening capacity building, management and supervision, as well as have improved the overall integration of health and social service workers providing person-centered care, resulting in positive health and other outcomes for the women and children served. Dr. Bernadette Madrid, Director of the Women and Child Protection Unit of the University of the Philippines Manila–Philippine General Hospital, shared that over the years they have documented "positive psychosocial and mental health outcomes of patients served by WCPUs, when assessed five or ten years after being seen at the Unit. These include positive changes in trauma symptoms, re-abuse percentages, teenage pregnancies and court results."

Social service workers hired by the units must have bachelor's degrees in social work and be registered by the government. Together, with the unit's assigned doctor and law enforcement officer, they undergo a rigorous four-week interprofessional training, which is reinforced by a two-week practical training at the hospital. During these two weeks, the team conducts joint home visits, interviews clients and attends case conferences, among other hands-on learning opportunities. According to Dr. Madrid, it is a worthwhile commitment when it comes to making real changes in how social work within health facilities is valued and with improving the dynamics of the teams.

> *"Training social workers together with doctors really helps with team building and teamwork. They learn together. Relationship building is very important in the Philippines, when you make referrals, relationships can really help. There are visible differences in the perception of social workers after multidisciplinary trainings. Before social workers were treated like clerks or someone making coffee, but after the training, doctors see how much value social workers bring to their work. It is almost a 360 degree turn. You can see how much social workers are appreciated in WCPUs. Our social workers are really on equal footing with doctors and work collaboratively as partners. I think that WCPUs have increased the status and value of social workers. The success of our training is now creating demand for capacity building from private hospitals and medical social workers. As part of institutionalization, women and child protection training has now been incorporated into the undergraduate medical curriculum and specialty training in Pediatrics and OB/GYN."*
>
> — Dr. Bernadette Madrid, Director of the Women and Child Protection Unit of the University of the Philippines Manila–Philippine General Hospital

[6] Dr. Bernadette Madrid interview by author.

When in roving or on-site single duty stations, or in interprofessional teams that are not trained together or poorly defined, the social service workforce can struggle to gain traction among other health professionals in taking meaningful action to address needs outside of the presenting medical issue (Dako-Gyeke, Boateng, and Mills 2018a; Chitereka 2010b). Faced with their colleagues' lack of understanding or appreciation of their role in providing services, they can be assigned tasks, such as paperwork, fundraising and distribution of charity goods, that do not allow them to practice their profession as taught or take advantage of their specialized skills (Sajid, Alvi, and Nawaz 2021b; Ciocănel et al. 2018b; Glaser and Suter 2016a).

The model in which the social service worker operates within a health facility is important, as evidenced by the improved health outcomes of patients receiving home visits from para professionals linked to a health facility (Kidman et al. 2014a; Thurman, Kidman, and Taylor 2015b; PEPFAR 2022), referred to an on-site social worker in emergency departments or inpatient settings (Auerbach and Mason 2010; Gordon 2001a; Steketee 2017a; Döbl, Huggard, and Beddoe 2015c; Pruitt et al. 2018a) and followed by an interprofessional team (case study on Philippines; Fraser et al. 2018a). With health and social services integrated either through the facility or team, patients have increased access to person-centered care—mindful of social and other determinants of health at play in treatment planning and adherence—and service providers are spurred to more holistic practice, taking both a biomedical and social work-oriented approach to care (HRH2030 2021; Global Social Service Workforce Alliance 2022). Within each of these models, the social service worker must be assigned or assume specific roles. The next section provides an overview of these roles and functions, distinguishing those that could be categorized as optimal versus others that could be shared with or shifted to other providers within the health facility.

Roles and functions

Social service workers in health facilities engage in a range of tasks or functions, both preventative and responsive, intended to enhance the physical and mental well-being of patients and their families. Which

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tasks are undertaken by these workers, as opposed to other workers in the facility or surrounding community, depend on a country's public health system and priorities, as well as the status of social work and broader social service professions, including labor market and current regulations around training and practice. Ideally, an assessment of the "optimal" roles for social service workers in health settings, versus other roles that are being performed by these workers but could be shared with or shifted to other providers, should be undertaken by relevant policy makers and administrators as part of workforce planning and management processes. Outcomes of such an assessment can help guide implementers on what should be considered when developing job descriptions for recruitment and performance evaluation, supervision and management of these workers in project-based or other integrated programming.

Below, the most frequently noted tasks or functions found in the literature and among key informants are grouped into "roles" for which both social work knowledge and skills are required (Fraser et al. 2018a). Certain tasks can be seen falling under multiple roles, such as applying assessment tools and facilitating communication, relationship building and advocacy. The key tasks/functions for each role are described in Table 2.

- **Behavioral health specialist:** Within health facilities, the social service workforce often conduct brief mental health or psychosocial support interventions with patients or refer patients to specialty mental health care or substance abuse treatment. This care can include basic psychosocial or emotional support, cognitive-behavioral treatment, problem-solving therapy or motivational interviewing, depending on the level of training and practice requirements. Yet in primary care and other frontline health settings, behavioral and mental health needs often go unnoticed or untreated, as doctors and nurses focus on addressing the presenting physical ailment (S. Craig et al. 2016; Reckrey et al. 2014).

  Social service workers in health facilities or as part of interprofessional teams bring their person-in-environment perspective, code of conduct, and training in biopsychosocial needs assessment to identify when patients may require mental health support to cope with their physical diagnosis (e.g., chronic or life-threatening disease), with a mental issue or illness (e.g., anxiety, depression), and with other life stressors (e.g., family relationship issues, lack of housing, food) (S. Craig et al. 2016; others). They may use group therapy or mediation skills to intervene in cases of crisis or conflict between the patient, family and/or providers. Social service workers' empathic and active listening skills may also be called upon by their peers or other health colleagues during disasters or epidemics, such as HIV/AIDS, Ebola and recently the COVID-19 pandemic, to cope with overwhelming workloads, stressful work environments and burnout (Pham et al. 2020; Chen and Zhuang 2020; A. Ross et al. 2021a).

- **Care manager:** Using their case management skills, social service workers in health facilities are often best placed to contribute to and coordinate patients' care plans, particularly for those who screen as high risk for social and other factors that can complicate access or adherence to treatment. Social service workers are trained to use standardized and functional assessments to appraise patients' potential barriers to and level of engagement with proposed treatment, and can see the bigger picture of how non-medical factors affect their care, while in the facility and after discharge. Social service workers facilitate communication among care team members as well as between patients, their caregivers and families (Monterio et al. 2016b). Mediation skills are also crucial to ensure patient's rights are upheld when crises arise that could affect care plan progress. Some even call for social service workers to claim this role from other health workers given the profession's roots in social justice, equity and human rights (Stanhope et al. 2015b).

- **Community engagement specialist:** Either in or linked to a health facility, social service workers often serve in a liaison or patient referral capacity. Drawing on their wide range of community resources and referral networks, cultural humility and advocacy skills, they help patients to navigate social service systems and empower them to solve concrete problems such as accessing financial support, locating affordable housing, and applying for other relevant benefits or social protection programs. With health workers facing time and cost-cutting pressure from facility administrators, there can be a push to discharge patients before such supports are in place, especially as finding, securing and following up on referrals can be labor intensive. Social service workers are best placed to ensure support packages are put in place before discharge. Drawing upon their professional values and training, they can assess, broker and coordinate interventions and care packages with a range of providers, in both the health setting and the community to which the patient will return.

- **Multi-level advocate:** From intake to discharge, social service workers in health facilities stand up for their patients' rights, to make decisions regarding their own care, and to address their non-medical needs. At the individual level, they work to empower patients with information on their diagnosis and treatment plan and intervene on patients' behalf with providers, caregivers and families. A statutory reporting function may also be part of this role where social services have a mandate to report cases of abuse or neglect. Their strong ties to the community and knowledge of available social services enable them to take their advocacy to the institutional and policy levels, lobbying for more equitable access to health services.

Table 2. Roles and illustrative functions of social service workers in health facilities

Behavioral or mental health specialist	Care manager	Community engagement specialist	Multi-level advocate
• **Apply standardized assessment tools** (Ashcroft et al. 2018; Glaser and Suter 2016b) • **Contribute to care plan, with focus on mental health needs** (Lahey et al. 2018; Steketee 2017b; Okafor et al. 2017a; Petersen 2021; Morris, Muskat, and Greenblatt 2018a) • **Provide brief mental health interventions, or make referral, depending on level of training (e.g., psychosocial or emotional support, counseling, therapy)** (Ciporen 2012; S. L. Craig, Betancourt, and Muskat 2015a; Chitereka 2010a; Spilsbury 2004) • **Enable patient and family coping with diagnosis/ difficulties resulting from illness** (Rowe et al. 2017b; Muskat, Craig, and Mathai 2017; Petersen 2021; Okafor et al. 2017a) • **Facilitate communication across providers or team members and between patient/family** (Döbl, Huggard, and Beddoe 2015a; S. L. Craig, Betancourt, and Muskat 2015a) • **Mediate between patients, families and providers in cases of conflict or crisis** (Ciocănel et al. 2018a)	• **Apply standardized assessment tools** • **Contribute to care plan, with focus on social, economic, and other environmental needs** (Pockett and Beddoe 2017; Chitereka 2010a) • **Monitor patient's progress on care plan** (Ciocănel et al. 2018a; Chitereka 2010a) • **Facilitate communication across providers or team members and between patient/ family** • **Coordinate discharge planning** (Glaser and Suter 2016b; Okafor et al. 2017a)	• **Apply standardized assessment tools** • **Identify needed resources and services outside of health facility based on patient assessment and care plan** (Petersen 2021; Glaser and Suter 2016b; Ashcroft et al. 2018) • **Support patients in navigating health and social service systems** (Glaser and Suter 2016b) • **Assist patients in accessing financial resources (e.g., subsidized medicines, payment plans, supplemental income, rental assistance)** (Rowe et al. 2017b; Steketee 2017b; Chitereka 2010a; Sajid, Alvi, and Nawaz 2021a) • **Assist patients in accessing other resources affecting their access to care or adherence to treatment (e.g., mental health intervention, transportation, food, legal services)** (Glaser and Suter 2016b; Muskat, Craig, and Mathai 2017; Ciporen 2012) • **Develop and maintain wide range of community resources/ referral networks** (Ashcroft et al. 2018; Glaser and Suter 2016b; Petersen 2021; Chitereka 2010a) • **Conduct home visits or other form of follow-up after discharge** (Chitereka 2010a; Kidman et al. 2014b; Thurman, Kidman, and Taylor 2015a)	• **Empower patients with information on their diagnosis, overall situation to be informed decision makers and take active role in their care** (Döbl, Huggard, and Beddoe 2015a; Petersen 2021; Morris, Muskat, and Greenblatt 2018b) • **Intervene with providers on patient's behalf when rights are ignored/ overlooked** (Auslander 2001; Glaser and Suter 2016b) • **Educate other providers on the role and contribution of the social service workforce to person-centered care** (Döbl, Huggard, and Beddoe 2015a) • **Engage with individuals, families and communities to identify problems and promote dialogue and action around solutions** (Sajid, Alvi, and Nawaz 2021a)

Models for training, management and supervision

A country's regulations around social service work—specifically minimum qualifications, certification or licensure, and scope of practice—critically inform which training, management and supervision models to introduce or further develop in health settings. Alongside major employers (e.g., ministries/departments of health or social welfare, health facilities, non-governmental or community-based organizations), academic and training institutions, and professional associations or councils should be considered key partners in any effort to plan for, develop and support the integration of social service workers into health care. Depending on the regulatory frameworks in place, these entities are the arbiters of training and professional practice standards. Even in settings where there is no formal legislation or regulatory framework, functioning professional associations can still play a de facto role in quality assurance and building the profession. Such is the case in Nigeria where medical social workers should all possess current registration with the Association of Medical Social Workers of Nigeria (Kayode Ogedengbe, interview by author, 18 May 2022). In LMIC, these entities are often better developed among health professions (e.g., medical unions, boards of nursing) than social services. Engaging both health and social service sectors' professional bodies in coordination with the major employers in a review of the current state of the workforce and the advantages of deploying the social service workforce in health facilities is essential for the success of any schemes for training, management or supervision of the social service workforce. Equally important is long-term collaboration between these sectors to ensure these successes are sustained.

In any such multi-sectoral review of social service workforce deployment, critical questions to be addressed should include the following:

- What is the status of the current regulatory or legal framework for social workers, and other social service workers? Does it include any specific regulations for practice in health settings?
- What current efforts are underway to address social, economic, and environmental determinants of health in the public sector health system? Which cadres of health and social service workers are involved?
- What training or education opportunities are there for students and current health and social service workers to build integrated care competencies and encourage a robust pipeline of qualified workers?
- How are these workers currently supervised and managed? How is the quality of services provided assured (e.g., registration, certification or licensing; recruitment and retention strategies for qualified staff)?

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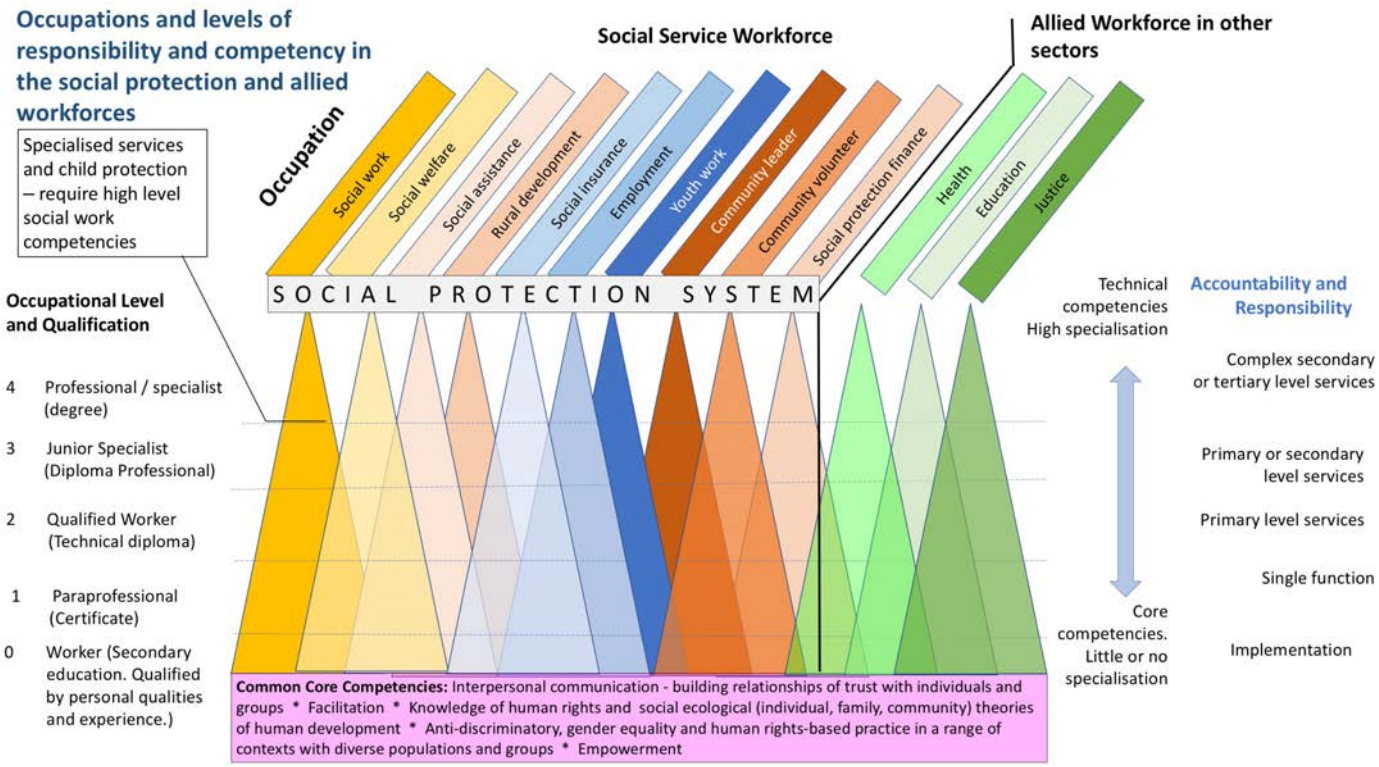
Training

The core competencies for the social service workforce in health facilities that were most cited in the literature and key informant interviews were: collaboration and teamwork, cultural humility, reflection, advocacy, partnership skills, interpersonal communication and empathy. However, these are not all unique to the social service workforce. As seen in Figure 1, it should be recognized that there are overlapping core competencies and qualifications among social service and allied workforce occupations. This overlap enables the flexible use of different deployment models detailed previously, depending on local capacity and requirements.

Minimum educational or training qualifications for the social service workforce in health settings vary from country to country, as well as among different types of workers and the model in which they are deployed. Most on-site hospital or medical social workers hold a bachelor's degree, whereas linked or roving social service workers have usually completed a short course or certificate, either alone (in the case of para professionals) or on top of existing health professional training (Albrithen and Yalli 2015; Okafor et al. 2017). A systematic means of measuring whether students have acquired the core knowledge and skills to demonstrate these competencies in the workplace, potentially via an adaptation of the Social Worker Integrated Care Competencies Scale (Saxe Zerden, Lombardi, and Jones 2019) or the United States' Council on Social Work Education's interprofessional practice competencies, could be of value when launching or bolstering training efforts (Interprofessional Education Collaborative 2016).

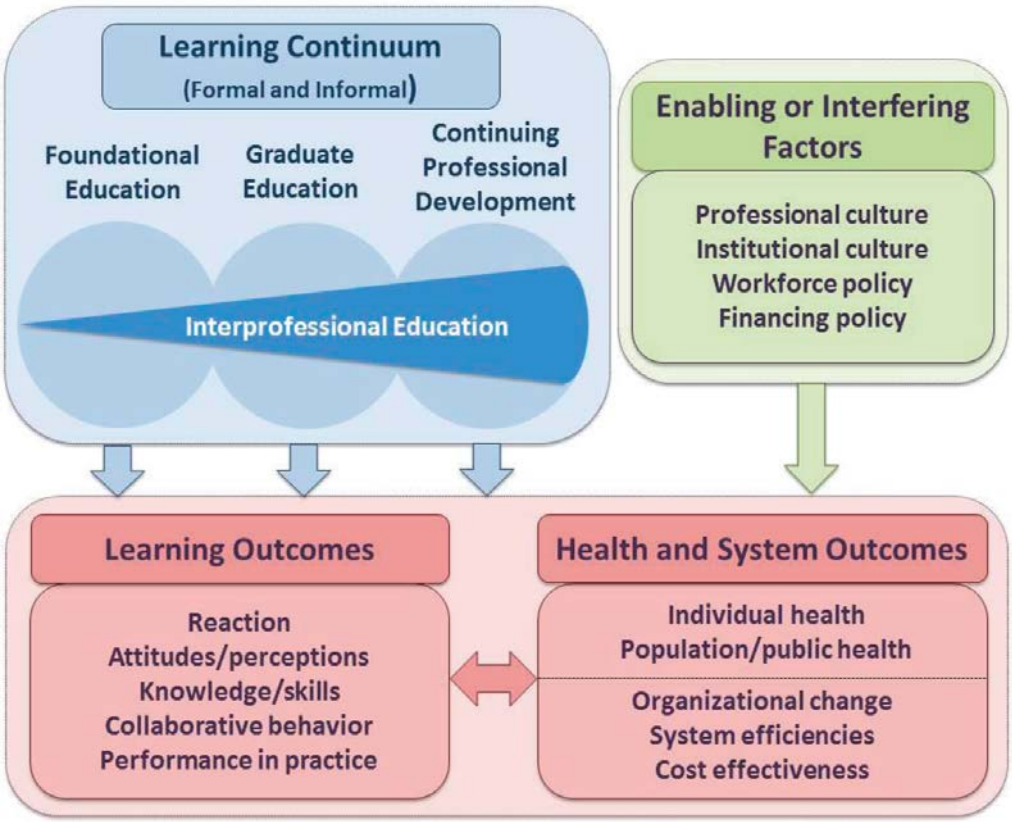
Figure 1. Qualifications and core competencies for selected examples of social service and allied workforce occupations



Source: UNICEF ECARO 2018

Interprofessional training can be hugely beneficial for developing mutual trust and cooperation across disciplines. This approach involves team members already trained in their own field (e.g., bachelor's in social work or nursing) attending joint training and field placements to cultivate appreciation for the specific value and perspective that each profession brings to providing person-centered, quality care (Feryn, De Corte, and Roose 2021; Glaser and Suter 2016a; Spitzer, Silverman, and Allen 2015). The most effective interprofessional training programs combine coursework with community-based practice, such as physicians or nurses joining home visits with social workers (National Academies of Sciences 2019; T. Browne et al. 2017). Field education is already a pillar of social work training, providing a solid starting point for designing and rolling out more interprofessional learning opportunities across the continuum (see Figure 2). At best, interprofessional education fosters the competencies most desirable among the social service workforce and their team members from other disciplines, like collaborative behavior, and attitudes and perceptions around caring for the whole person. In participating in joint training and education, each of the professions brings its own culture and attitudes toward each other and how they deliver services, which can, if not deliberately addressed and overcome, limit their level of participation or commitment to interprofessional training. Conflicting academic calendars or requirements for the different professions, can pose logistical challenges to launching or maintaining this approach to training (National Academies of Sciences Engineering and Medicine 2019).

Figure 2. The interprofessional learning continuum model



Note: For this model, "graduate education" encompasses any advanced formal or supervised health professions training taking place between the completion of foundational education and entry into unsupervised practice.

Source: IOM, 2015, via NASEM 2019 Report.

While social work education may better prepare graduates to see the "whole person" in their approach to assessment and care planning than other health cadres, some United States-based researchers have cited less "wider lens" coursework on health equity, social determinants of health, health prevention and health practice evaluation resulting in views of health social work as a specialty rather than a defining characteristic of all social work and limiting true progress of integrated care (Ruth et al. 2017). Equally, a focus on clinical skills only, such as in addressing behavioral health, abuse and violence, and substance use and addictions, is insufficient to ensure a robust pipeline of social service workers are prepared to address more upstream factors associated with health disparities, regardless of their deployment in health facilities or other institutions. Reorienting education and training of the social service workforce according to the Social Work in Health Impact Model (see Figure 3), which elevates prevention and population health, has the potential to enhance their contributions to health care far beyond day-to-day clinical interactions, to systems- and society-level impact (Ruth et al. 2017; A. M. Ross, Traube, and Cederbaum 2021).

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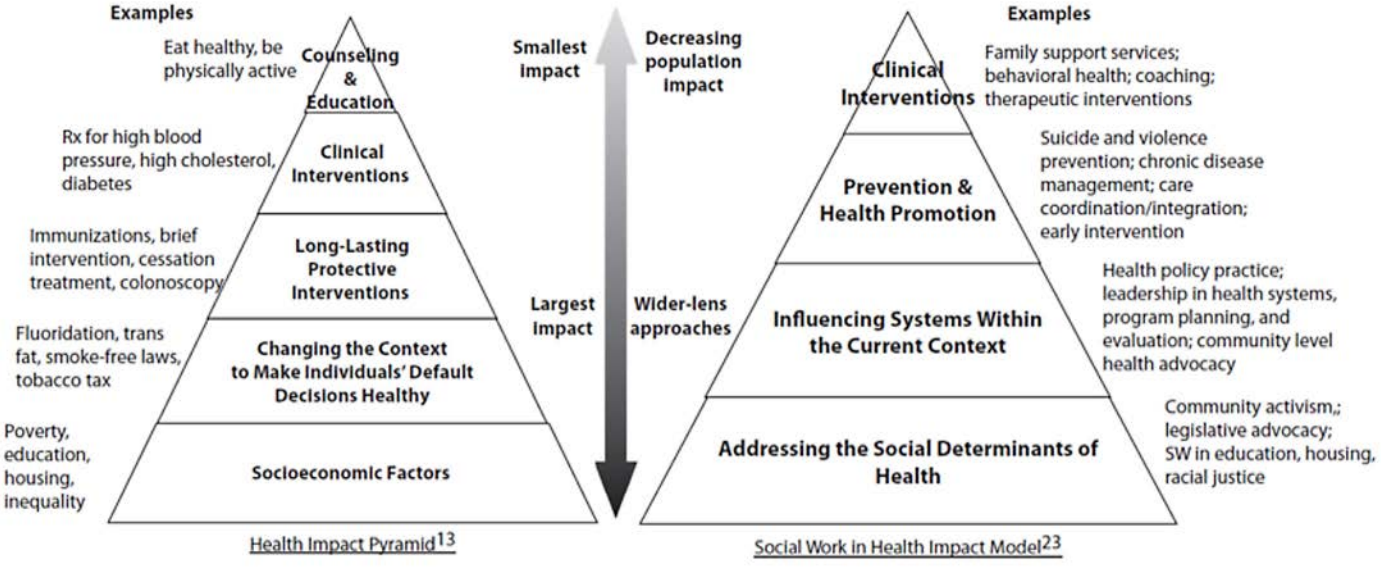
Figure 3. Health impact pyramid and social work in health impact model



Source: Ruth et al. 2017; A. M. Ross, Traube, and Cederbaum 2021

Management and supervision

How social service workers are deployed, either linked to a health facility or located on site, influences what is possible for their management and supervision. Four options, along with the main advantages and disadvantages of each, were distilled from the literature and key informant interviews and can be found in Table 3.

The challenges that can result from already trained social service workers being recruited and managed by the health sector are evident from an example in South Africa, where child and youth care workers have been sought by health facilities to undertake care management and home visits for HIV/AIDS-affected children and families under the ISIBINDI Impilo model (Sbongile Mzulwini and Zeni Thumbadoo, interview by author). Their existing skills and experience in working within the life space of children and families, building trusting relationships and a sense of safety as they work together on parenting, school attendance, and navigating health and social protection systems, is highly valuable. Yet when they are working with health facilities, they receive supervision from a facility head or other staff member unfamiliar with their practice philosophy and values. Having a suitably trained and qualified supervisor for the social service workforce in health facilities is key to reinforcing key competencies, motivation and retention of staff (T. S. Davis et al. 2015). It helps prevent burnout and facilitates professional development and career progression.

Table 3. Key advantages and disadvantages of management and supervision options

Type of inter-sectoral arrangement	Advantages	Disadvantages
1. Social service workforce employed and supervised by social services department but linked with a specific service or cluster of services in the health sector	Achieves some of the benefits of service integration and interprofessional work, but at a lower cost. One worker can cover a cluster of local services with less fiscal and managerial commitment required by the health sector.	Such linking arrangements may not allow for sufficient coordination to achieve the enhanced outcomes for services users. This is particularly true if allied sector staff do not fully trust, recognize or know how to involve the social service workforce in their service.
2a. Social service workforce recruited, paid, managed and supervised by social services department but physically deployed to a specific service in the health sector (stated in job description)	Achieves the main benefits of joint work that are accomplished by colleagues across sectors being co-located, but without requiring significant cost and commitment from the allied sector.	The lower level of ownership by management of the allied sector may result in lower commitment to making the physical deployment effective.
2b. Social service workforce recruited, paid, managed and supervised by the health sector or service where they are deployed	Strong ownership by the health sector or service where the social service workforce is located. Clear management and reporting lines.	The management and colleagues at the health facility may not be able to meet the supervision and professional development requirements of the social service workforce.
2c. Social service workforce recruited, paid, managed and supervised by the health sector or service where they are located but supervised by a social worker within the social services department (See "Where there is no supervisor" case study)	Same as 2b but added advantage of receiving supervision (incl. support for learning, professional development and reflective practice) from a qualified, experienced social worker to strengthen their practice in that setting.	The social service worker could receive conflicting advice from their service manager and colleagues on-site versus from their off-site social work supervisor.

CASE STUDY:

Where there is no supervisor: Using field education to expand social work supervision and integrated services

To rapidly increase and better distribute the workforce providing mental and other behavioral health services to children, youth and other vulnerable populations, the United States' Health Resources and Services Administration launched its Behavioral Health Workforce Education and Training Program for Professionals in 2014. Through grants to accredited United States-based training programs, it supports clinical internships and field placements for social work, counseling, psychology, and other mental and behavioral health students. The School of Social Work at the University of North Carolina (UNC) at Chapel Hill was among the first cohort of institutions to receive this funding. Referred to as PrimeCare, this project at UNC has trained over 400 master's level social workers to work in integrated primary care settings. Students achieve the nine core competencies of integrated care through courses in social work and across other disciplines, like public health and medicine, and highly integrated field education or practical training.[7]

In their final year of training, student receive a stipend so that they can afford to focus on working and learning full time in their assigned field site.

According to Dr. Lisa Zerden, Principal Investigator for UNC-PrimeCare, Associate Professor and Senior Associate Dean for Master of Social Work Education at UNC's School of Social Work, after the first grant, she and her team began receiving calls from across the state for student placements. Yet for some facilities or agencies serving populations with the greatest need for integrated care, there was not a qualified staff member on site who could fulfill the required role of field supervisor for these students. To address this challenge, Dr. Zerden and her team incorporated a funded, full-time project coordinator position into their next grant, so that when a field site did not have supervision capacity, the coordinator could step into that role. With another $1.92 million grant awarded to train 116 Master of Social Work students in trauma-informed care for children, youth and families by 2025, UNC-PrimeCare is committed to continue contributing to a social service workforce equipped for integration into health settings and in areas where they are needed most.

[7] Nine core competencies of integrated care include: interpersonal communication, collaboration and teamwork, screening and assessment, care planning and coordination, intervention, cultural competence and adaptation, systems-oriented practice, practice-based learning and quality improvement, and informatics.

Costs and cost savings

For the social service workforce to be integrated sustainably into health settings and teams, there must be a careful estimation of the required costs so that they can be budgeted for by the hiring sector, facility or other source of funding. Most support for such positions can be expected to come from a country's civil sector payroll, the health facility's direct hiring budget, or in some cases, from external donor funding. In other cases where national or private insurance schemes are in place, reimbursable services provided by the social service workforce can support all or part of their costs (e.g., salary, employee benefits, office space, supplies, transportation).

To justify the allocation of such funds, cost-benefit models, like the one developed for social workers in emergency departments in the United States, can be adapted to show the costs of the position or positions alongside the net benefit or savings. Using informed assumptions or available data points, this model demonstrates scenarios in which the savings exceed, are even with, or are less than what is expended to have a full-time worker on board, depending on the patient volume of a facility (Gordon 2001b; Silverman 2016). Examples of these assumptions and data points include: the percentage of patients who would see a social worker, number of return visits and/or hospital admissions that may be prevented by social work intervention, costs of a return visit/day of hospitalization, amount of time spent by medical staff on social needs, and the hourly wages of medical staff. An interesting exercise would be to pursue adaptations for different high-priority health settings (primary care, antenatal and obstetric care, pediatrics, HIV/AIDS and other chronic disease management) in LMIC based on this and other related models.

Efforts to advocate for investment in deploying social service workforce in health settings can be strengthened by evidence of how, when this deployment is effective, supported and sustained, it can contribute to cost savings, both for the government and other bodies funding health services, as well as for the patients themselves (Rogan and Bradley 2016). As described in previous sections on models for deployment and roles, the social service workforce addressing non-medical issues affecting care through holistic prevention and intervention approaches has the potential to improve health outcomes, reducing use of higher-level care such as emergency departments or NICUs, hospital admissions and readmissions, and length of stay. Some of the most used measures to approximate cost savings include reduced physician or clinic visits, use of emergency department or other higher-level care, and hospital admissions. Other measures used to estimate cost savings include cost per bed day, medical claims and worker perceptions. Medical social workers' perceptions of their contributions to person-centered care have also been studied, with maximization of hospital and community resources emerging as a top theme, thanks to their role in ensuring patient stability in more than their medical issues ahead of discharge (S. L. Craig, Betancourt, and Muskat 2015b).

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Cost savings from deployment of social service workforce in health settings

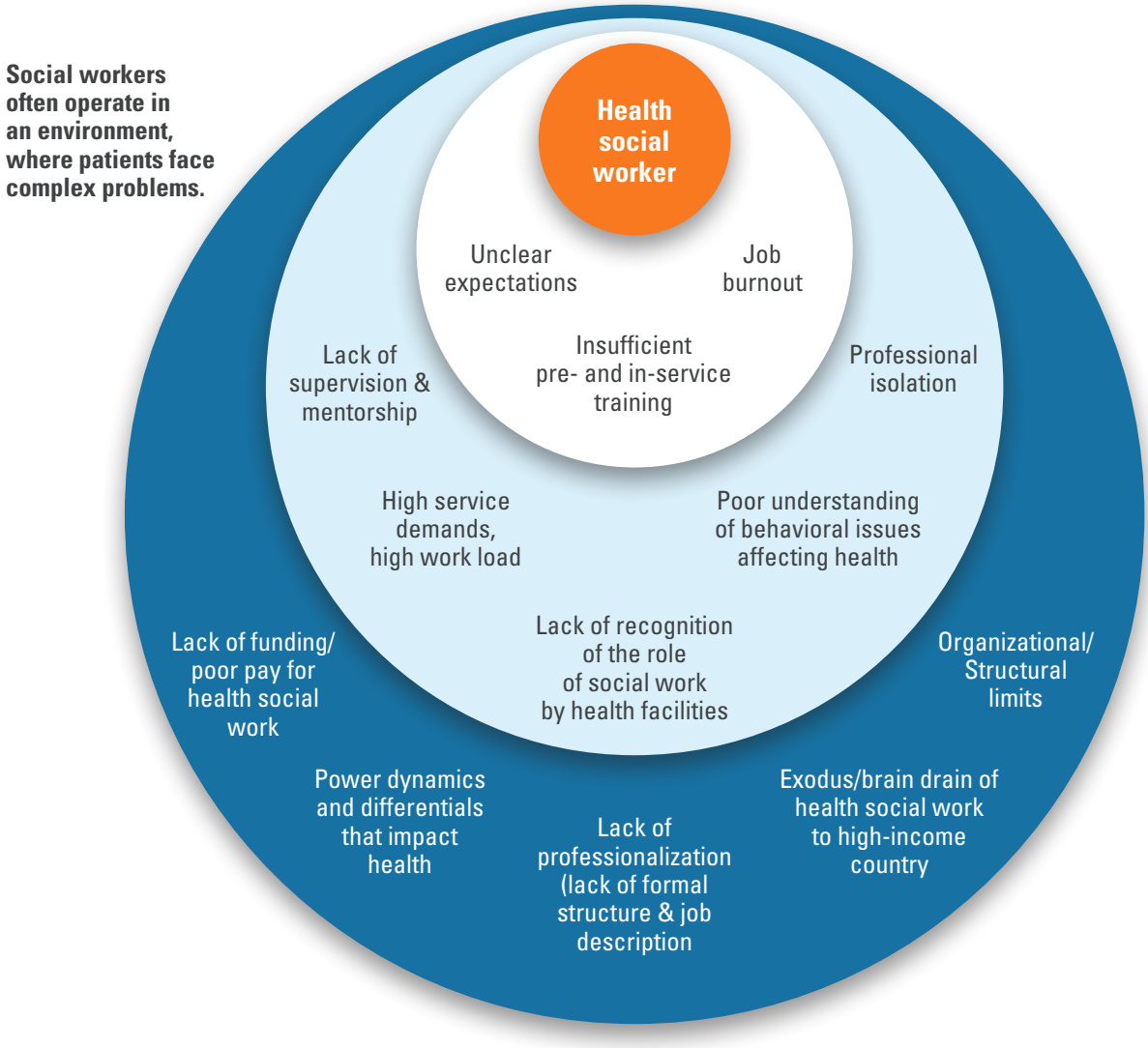
- In a review of three decades of international research on the effects of social work services on health and cost outcomes, nearly all studies reported cost savings, from reduced emergency room and hospital visits among high-risk adults saving $107,808/year to reduced NICU admissions among high-risk pregnant women **saving $1,875,463 over four years or a $2 estimated return on each dollar invested** in the multidisciplinary, care management intervention (Steketee 2017a).
- A review of integrated models of health and social care among primarily low-income populations showed **decreased health care costs linked to care coordination and community outreach interventions,** primarily based on decreased visits, admissions and lengths of stay (Taylor et al. 2016).
- A study of care coordination provided by an interprofessional team in eight primary care clinics serving low-income beneficiaries in the United States saw reductions in emergency room visits and admissions, with **$1,643 per patient saved** compared to controls (The Commonwealth Fund 2017).
- A study of the hospitalization rates of emergency room patients seen by social workers in a large, urban hospital in the United States showed that **only 16 per cent were admitted to the hospital,** with larger proportions directed to more appropriate referral services (Auerbach and Mason 2010).
- In one of the first economic evaluations of a hospital-based social work initiative in Australia, the **average length of stay was reduced by 33 days** compared to controls, which based on the "per bed" implementation costs of the initiative represented an efficient use of resources and was adopted permanently by the hospital (Osborne et al. 2018).
- An analysis of medical claims data of 2,718 United States-insured Medicare/Medicaid patients revealed a **10 per cent reduction in healthcare costs** for those connected to social services (Pruitt et al. 2018).

Despite growing evidence, it is often hard to produce quick justification of the funds involved in deploying the social service workforce to health facilities. Investment in integrating services and addressing upstream factors affecting health is often a long-term process and results are not immediate (National Academies of Sciences 2019). There is little existing economic modelling to build on in the social service sector, compared to health or education (Bilson et al. 2017). Additionally, health care cost savings from social service interventions are not always directed back to the agency or facility investing in them, which works against collaboration efforts between the health and social service sectors (Taylor et al. 2016). A shift from fee-for-service to value-based care payment models was promoted frequently in the literature to encourage integration and pooling of resources between these sectors. In the United States, this approach has been put into practice through medical homes or accountable care organization arrangements, where practitioners or facilities accept responsibility for a group of patients for a fixed amount of funding (Ewald, Golden, and Mason 2021; Coyle 2022; Stanhope et al. 2015; National Academies of Sciences 2019). When paired with care management and an interprofessional team approach for the highest-risk patients, accountable care homes have been shown to generate substantial savings (in one case, $21.8 million over two years, with half earned by the facility itself) (The Commonwealth Fund 2017; Hostetter, Klein, and McCarthy 2016). Additional investigations, especially in LMIC, that can tie cost savings back to the facilities and sectors investing in such arrangements, should be a priority for strengthening the economic case for the social service workforce in health settings.

CHALLENGES AND OPPORTUNITIES

Social service workers in health settings encounter various challenges in fulfilling their day-to-day work, and in longer-term professionalization efforts. Yet for many of these challenges, there are examples of how policy makers down to social service workers themselves are seeking out opportunities to address them. Figure 4 synthesizes the most prominent challenges noted in the literature and by key informants. Examples of opportunities to respond to these challenges at each of the three levels—individual, organizational and policy—are presented to encourage implementers and decision makers, in countries seeking to introduce or strengthen the deployment of the social service workforce in health facilities, that progress towards this overall goal is possible.

Figure 4. Challenges and risks to the social service workforce in health facilities by level



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Individual level

Job burnout is a common risk among the social service workforce in health settings, both where the profession is well established and where it is developing. Often charged with caring for the most complex patients, social service workers routinely face mentally taxing ethical and moral dilemmas, demanding workloads and limited resources for referrals, which can lead to dwindling job satisfaction, secondary trauma, staff turnover and burnout (Padin et al. 2021; Ambrose-Miller and Ashcroft 2016; Dane and Chachkes 2001). In Zimbabwe, these pressures, concurrent with an economic crisis, created conditions for an exodus of health social workers to high-income countries, which affected delivery of social services in hospitals serving vulnerable populations (Chitereka 2010).

Social service workers may also encounter professional status conflicts and poor recognition, which can inhibit their agency and ability to perform tasks that utilize their specialized knowledge and skills (Ciocănel et al. 2018). In some country contexts, especially in LMIC, where an entrenched medical model prevails, there is little or no appreciation for biopsychosocial approaches, thus diminishing social worker roles and inhibiting effective social work integration in health care (Ashcroft et al. 2018). In authoritarian and hierarchical types of health systems, lack of understanding of the value and unique roles played by the social service workforce can put them at the bottom of the facility hierarchy with little professional recognition or power (Chitereka 2010). Such power differentials can affect workers' ability to influence ethical decision-making processes or standards of care overall, isolating these workers and rendering them unable to fully participate in effectively supporting their patients (Ambrose-Miller and Ashcroft 2016; Dako-Gyeke, Boateng, and Mills 2018). Social workers may end up performing functions that do not fit their role and qualifications, unable to practice to the top of their scope (Glaser and Suter 2016; Sajid, Alvi, and Nawaz 2021).

These systemic barriers can further feed into negative perceptions of the work setting, poor physical and mental well-being, and overall job dissatisfaction and burnout (Ashcroft et al. 2018; Padin et al. 2021). Yet at

this level there are still opportunities to combat some of the factors contributing to burnout and high staff turnover. While measures such as salary adjustments or increased professional recognition require more sustained action at the policy level, steps can be taken among individual staff and facility teams to initiate trainings in coping skills, formal or informal peer-to-peer supervision, or even physical changes to the workplace that can contribute to increased satisfaction, such as a dedicated space for patient and family meetings and counseling (Padin et al. 2021; Spilsbury 2004). As shared by one key informant, "satisfaction in your job is relative, the most basic thing outside of salary is a good working environment. When we're working in an environment in which you can't express your professional ability, it is not conducive to getting the best for your patient. Environment is an incentive!"[8]

Organizational level

Many of the challenges stemming from the individual level can be addressed at the organizational level. For example, one of the most effective means of communicating the value and important role of the social service workforce alongside other health workers, and ultimately helping the whole care team to focus on patient outcomes and not just service delivery alone, is through interprofessional training or education and the formation of such teams in facilities. Learning side-by-side in the classroom, in-field practice and in day-to-day interactions with patients, targets the biases and misconceptions at the root of this challenge. It is up to the accrediting bodies, training and educational institutions, and professional associations to promote and codify this approach via minimum standards and practice requirements. In the interim, department heads and faculty can promote interprofessional training by seeking opportunities to teach across disciplines, cross-pollinating practice with the importance of social determinants of health and cultivating the needed competencies for integrated and person-centered care (Ambrose-Miller and Ashcroft 2016; Feryn, de Corte, and Roose 2022).

Policy level

Lack of funding for creating and maintaining position salaries, office space and other resources is a pervasive challenge for effective deployment of the social service workforce in health settings, with effects felt at every level (Döbl, Huggard, and Beddoe 2015a; Chitereka 2010a; Sajid, Alvi, and Nawaz 2021a). In some countries, health social workers are often unable to sustain their families due to low salaries (Chitereka 2010). Lack of funding affects the recruitment of additional social service workers, which can lead to a limited number of workers covering several hospitals, overstretching themselves and contributing to staff turnover and burnout (Dako-Gyeke, Boateng, and Mills 2018; Padin et al. 2021). Working against the backdrop of already limited resources for their patients, funding constraints create additional tensions and barriers for social service workers to effectively perform their functions, such as conduct home visits or follow up with discharged patients if there is no vehicle or transportation reimbursement available.

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[8] Interview with Kayode Ogedengbe, by author.

Opportunities to effect changes in funding are most often encountered at the policy level, through budget allocations enacted via legislation or other directives by national or subnational governments, health and social welfare departments, and/or facility heads. Supporting local efforts to test and produce evidence to justify such funding is a key role for donors and program implementers seeking to spur action around the social service workforce in health settings. In Romania, an interprofessional team approach to community health and social care was piloted with funding from UNICEF in 34 rural and four urban municipalities. A minimum package of health, education and social protection services were delivered to the most vulnerable families by a social worker, community health nurse and school counselor linked to a general practitioner's office but operating out of city halls. An evaluation of the model highlighted its effectiveness in reducing or eliminating different vulnerabilities in participating geographic areas, such as children at risk of violence and unvaccinated children. This locally generated evidence has fueled advocacy efforts by UNICEF, local government, and the Romania Association of Social Workers to incorporate this model for scale up within the 200 planned community care centers as part of the national resilience plan, in addition to broader calls for increasing the number of salaried social work positions in hospitals (UNICEF 2021b).

In addition to advocacy for funding, there is a linked need for lobbying by professional associations, employers and workers themselves for increased professionalization of the social service workforce in many LMIC contexts where there is no or limited legislation or other regulatory framework in place. Such a framework raises the visibility and gives greater legitimacy to the important role that these workers play, not only in health facilities, but in the education, justice, and social welfare sectors on behalf of vulnerable children and families. Raising the professional profile of social service work will aid in recruitment and retention of qualified workers, which when deployed to work alongside their health colleagues, can make a significant difference in improving the health outcomes and costs of delivering health care for all.

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DISCUSSION AND RECOMMENDATIONS

As presented throughout this paper, there is great value in deploying the social service workforce to work within and linked to health facilities. Evidence from the literature and key informants reinforces the important roles that a social worker, care coordinator, community liaison or other social service cadre can play in addressing patients' non-medical needs and contributing to better immediate health outcomes, lower health care costs, and improvements to overall well-being and stability. The following recommendations, organized by the three action fields of the Social Service Workforce Strengthening Framework (Global Social Service Workforce Alliance 2010), build on this paper's discussion of how best to train, deploy, manage and supervise these workers in health settings. They are not exhaustive, but rather reflect the top considerations for policy makers, program implementers, civil society and advocacy groups to ensure that any model or approach to deploying the social service workforce in a health setting is effective and sustainable.

Planning for the deployment of the social service workforce in health facilities

- **Inter-ministerial leadership and coordination of "workforce for health" planning processes.** Ministries of health, social welfare and related civil service administrative bodies must work in tandem to determine the extent to which the social service workforce is integrated into public sector facilities, and how responsibility for hiring and managing these workers is to be taken on by health or social service departments, or facilities themselves. Regardless of which model of deployment chosen,

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all actors involved in planning a "workforce for health" should understand the key roles played by the social service workforce in health settings and the implications of introducing or sustaining social service workforce positions in facilities. Ministries of health and social welfare should work collaboratively to develop recommended staffing norms inclusive of the social service workforce with requisite budget support, prioritizing facilities serving high volumes of low-income patients, or patients with chronic diseases or other complex needs. Workforce data should be shared between the sectors and used to inform the planning process and document the outcomes of these deployments on health and other strategic development indicators as part of justifying this approach in future planning and budgeting cycles.

- **Adequate budget and other forms of resourcing,** including office space and meeting rooms, need to be factored into long-term planning for health facilities in which the social service workforce play a role. Whether they are funded at the ministry or facility level will depend on the country context, but in both cases the funding must ensure that the social service workforce working in health settings not only be offered a competetive salary to attract skilled and experienced professionals, but also dedicated space equipped with a computer and telephone for liaising with other professionals and agencies for referrals, documenting interactions with patients and updating care plans, and conducting confidential meetings with patients and their families to discuss sensitive social welfare issues. Transport costs are also an important resource to enable home visits and planning meetings together with social service departments and other community organizations in the patient's home district.

Developing the social service workforce for engagement in health facilities and teams

- **Interprofessional learning opportunities should be cultivated** within pre-service education, in-service training and continuing professional development for the social service workforce intending to or currently practicing in health settings, alongside health profession students and colleagues. Such coursework is essential to ensuring successful integration, mutual respect and recognition across the disciplines involved in integrated care. Efforts can start small, by allowing students or workers to fulfill graduation or in-service training requirements in other departments or by inviting guest lecturers from different disciplines into established courses, both with the aim to expand offerings on social and other determinants of health, prevention, health promotion, equity and social justice, and population health. These efforts could be advanced by the development of a suitable competency framework for the social service workforce in health settings, such as the Social Worker Integrated Care Competencies or Interprofessional Practice Competencies, and even further through adoption of standards related to integrated care by professional councils, associations or accreditation bodies involved in certifying the training or qualifications of social service workers practicing in health settings.

- **Field placements (practicum) based in health facilities should be made available** for all social service workforce cadre trainees, and ideally, corresponding opportunities for community-based practice should be made available for medical, nursing and other health profession students planning to enter integrated care. Such field placements enable students to practice their skills in a supervised, real-life environment and gain an unparalleled understanding of the barriers patients face to accessing and adhering to prescribed care as well as the resources available locally to address them.

Supporting the performance and recognition of the social service workforce in health facilities

- **Regular, supportive supervision for the social service workforce in health settings is vital and should not be overlooked,** even if the most appropriate supervisor is not based at the same site. If off-site or remote supervision by a qualified social worker, child and youth care worker, or other cadre is provided it should be coordinated with the on-site management with oversight by medical or administrative staff. Technical supervision and coaching may need to be provided by medical or other specialist staff when social service workers are involved in interprofessional teams. Group supervision (either led by peers or an expert group supervisor) can also be an effective means of ensuring support, and promoting reflective practice, learning and professional development.

- **Normative and policy framework to support recognition of the social service workforce and quality assurance.** The mandate, role and duties of the social service workforce in health settings needs to be explicitly set out in primary and secondary legislation, and in policies and procedures governing health settings. In many LMIC, such normative and policy frameworks are not in place for social work as a profession, let alone for other social service workforce cadres. This reality undercuts recognition of these workers' important contributions, unique preparation and scope of practice within health and other settings, as well as the ability to assure the quality of their work. Professional associations play a key role in raising professional and public awareness of the role played by the social service workforce, in developing and promoting quality standards for the workforce, and in advocating for the support and resources they require to work effectively. They should be considered allies, even leaders, in the development and implementation of these frameworks, aiding in the creation of minimum education and practice standards, job descriptions, and roles and responsibilities (including statutory protection responsibilities) of the social service workforce in different health settings, all of which need to be defined in legislation and policy documents, to ensure their mandate is recognized and supported by facility directors and administrators, managers and health colleagues.

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ANNEXES

Annex 1. List of key informant interviews

Country/ region covered	Interviewee name, affiliated organization	Title, Affiliated Organization
Asia Pacific	Masahiro Zakoji	Technical Officer, Health Workforce Policy and Health Care Delivery, WHO Regional Office East Asia Pacific
Romania/Eastern Europe	Oana Motea	Health Specialist, UNICEF Romania
Ethiopia	Befikadu Berhanu	Ethiopian Society of Sociologists, Social Workers, and Anthropologists (ESSSWA)
	Endeshaw Yemane	OVC Director, Mekdim Ethiopia National Association
	Grace Mayanja	Chief of Party, USAID Caring for Vulnerable Children Activity, Ethiopia FHI 360
Global	Paul Marsden	Technical Officer, World Health Organization; Health Workforce Team Lead for the joint WHO-ILO-OECD Working for Health programme and its Multi-Partner Trust Fund
Nigeria	Kayode Ogedengbe	National President, Association of Medical Social Workers of Nigeria (AMSWON)
Philippines	Bernadette J. Madrid	Director of the Child Protection Unit (CPU) of the University of the Philippines Manila – Philippine General Hospital; Associate Clinical Professor of Pediatrics; Executive Director of the Child Protection Network Foundation, Inc.
South Africa	Sbongile Mzulwini	Regional Project Manager, National Association of Child Care Workers in South Africa (NACCW)
	Zeni Thumbadoo	Deputy Director, National Association of Child Care Workers in South Africa (NACCW)
Multiple countries/ Sub-Saharan Africa	OHA/OGAC group interview	Maury Mendenhall, Senior Technical Advisor for OVC, OHA/USAID; Sally Bjornholm, Senior HIV Technical Advisor, USAID; Lauren Murphy, Senior Technical Advisor for OVC, USAID; Amy Aberra, Policy Analyst, USAID
USA/Global	Lisa de Saxe Zerden	Associate Professor and Senior Associate Dean for MSW Education at the University of North Carolina at Chapel Hill School of Social Work; Interprofessional Education (IPE) Director; Founding Member of Office of Interprofessional Education and Practice at UNC-Chapel Hill; Research Fellow with the Health Workforce Research Center at the Cecil G. Sheps Center for Health Services Research
Zimbabwe	Collen Marawanyika	USAID/Zimbabwe
	Richard Savo	Deputy Chief of Party/Technical Director, Pathways Project, Catholic Relief Services

Annex 2. Key informant interview guide

Hello, my name is _____ and I am collaborating with the Global Social Service Workforce Alliance as part of a joint project with the United States Government Advancing Protection and Care for Children in Adversity (APCCA) Secretariat's Global Social Services Workforce Working Group (USG-GSSW) to review existing research and promising practices around the optimal role and function of social service workers when located in or linked to health facilities. The reason I am contacting you is because we are gathering information from a select group of experts and implementers on the roles of social service workers in health facilities, as well as models or approaches for recruitment, deployment, training, management and funding of these workers, and I would like to ask you some questions about your experience at the country, regional and/or global level. The Alliance defines the social service workforce as:

'An inclusive concept referring to a broad range of governmental and nongovernmental professionals and para professionals who work with children, youth, adults, older persons, families, and communities to ensure healthy development and well-being. The social service workforce focuses on preventative, responsive and promotive services that are informed by the humanities and social sciences, Indigenous knowledges, discipline-specific and interdisciplinary knowledge and skills, and ethical principles. Social service workers engage people, structures, and organizations to facilitate access to needed services, alleviate poverty, challenge and reduce discrimination, promote social justice and human rights, and prevent and respond to violence, abuse, exploitation, neglect and family separation. The social service workforce constitutes a broad array of practitioners, researchers, managers and educators, including, but not limited to social workers, social educators, social pedagogues, childcare workers, youth workers, child and youth care workers, community development workers/community liaison officers, community workers, welfare officers, social/cultural animators and case managers.'

Gaining insight through key informant interviews is important to better understand the successes and challenges of different models and approaches being employed in different countries and may enable those who recognize the value of the social service workforce (including policymakers, civil society, advocacy groups) to make a compelling case for government funding or other resources to support and strengthen this workforce. All the information you provide will help guide our review across countries, and to develop our final analysis and recommendations. We hope to share our findings with you early next year. If it's acceptable to you, your name and organization may be mentioned in the final report. It will not be attached to what you say in this interview. What you share during this conversation is confidential and will be de-identified. We can also skip any question you prefer not to answer.

Do I have your permission to proceed?

Date of Interview:	
Name and Title of Interviewee:	
Institution:	
E-mail Address:	

1. Could you describe your and/or your institution's involvement with social service workers located in or linked to health facilities?
2. In your experience, what types of social service workers are typically engaged by health facilities or health settings? What roles do they undertake and how have these roles changed, if any, over the course of the COVID-19 pandemic?
3. Could you describe the different models or approaches to recruiting, deploying, managing, or funding of social service workers in health facilities that you have been involved in or observed? What have been the results? Who were the key actors involved and what were the main steps in putting these models in place?
4. What were the enabling factors for successful integration/deployment of social service workers in health care facilities?
5. What are the greatest challenges or risks that social workers/social service workers typically face, when working in health care facilities or institutions *(with service users and/or with colleagues, managers, working conditions)*? How could such challenges be addressed or mitigated?
6. What evidence are you aware of for the contribution of the services and support provided by the social service workforce to the health and child protection outcomes for the children and families involved? Could you share electronic copies or links to any related resources?
7. What examples are you aware of, if any, of cost-benefit analysis of the social service workforce in health facilities, or other cost-related studies that could help inform an investment case?
8. What are the key planning considerations to ensure that any model or approach to deploying the social service workforce in health facilities is effective and sustainable?
9. What recommendations do you have for establishing or accelerating the deployment of social service workers in health facilities? What do you see as the top priorities for investment?
10. Who else would you recommend that we interview on this topic?

Country-Specific Questions

11. What type of training or other qualifications are required to work as a social worker / social service worker in or with a health facility? What types of education or training do you think should be provided in the future to better prepare the social service workforce for these roles?
12. How are social service workers in health settings regulated where you work/in your country? e.g., policy, licensing or registration requirements, professional body, etc.
13. How are these positions typically funded where you work/in your country?
14. How are social workers/social service workers in health care settings 'supervised' in your district/country? We define 'supervision' as 'a supportive relationship, carried out in regular meetings, which focus on accountability, well-being and skill development. Through regular contacts, the supervisor provides coaching and encourages the supervisee to critically reflect on their practice'. (Guidance Manual on Strengthening Supervision, Global Social Service Workforce Alliance, 2020).
15. Do you have any examples of how a social worker / social service worker, or workers, located in a health facility, positively contributed to the well-being of the children, families, and communities in your district/country? If so, please share.

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