World Health Organization

# Global Competency Framework for Universal Health Coverage

World Health Organization

# Global Competency Framework for Universal Health Coverage

Global Competency Framework for Universal Health Coverage

ISBN 978-92-4-003468-6 (electronic version)
ISBN 978-92-4-003469-3 (print version)

**© World Health Organization 2022**

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (http://www.wipo.int/amc/en/mediation/rules/).

**Suggested citation.** Global Competency Framework for Universal Health Coverage. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

**Cataloguing-in-Publication (CIP) data.** CIP data are available at http://apps.who.int/iris.

**Sales, rights and licensing.** To purchase WHO publications, see http://apps.who.int/bookorders. To submit requests for commercial use and queries on rights and licensing, see http://www.who.int/about/licensing.

**Third-party materials.** If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

**General disclaimers.** The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Design: L'IV Com Sàrl

# Contents

Glossary iv

Executive summary viii

1. Using the Global Competency Framework for UHC 1

    1.1 Competency-based approach to education rooted in population health needs 1
    1.2 Specification of competency-based practice standards 2
    1.3 Competency-based approach to the design and delivery of education programmes 3
    1.4 Incorporation into individual health worker learning and professional behaviour 5

2. Competencies for universal health coverage: overview 6

3. Competencies and behaviours for UHC 8

    Domain I: People-centredness 8
    Domain II: Decision-making 9
    Domain III: Communication 10
    Domain IV: Collaboration 11
    Domain V: Evidence-informed practice 12
    Domain VI: Personal conduct 13

References 14

# Glossary

## Education

| | |
|---|---|
| **Attitude** | A person's feelings, values and beliefs, which influence their behaviour and the performance of tasks. |
| **Behaviour** | Observable conduct towards other people or tasks that expresses a competency. Behaviours are measurable in the performance of tasks. |
| **Competence** | The state of proficiency of a person to perform the required practice activities to the defined standard. This incorporates having the requisite competencies to do this in a given context. Competence is multidimensional and dynamic. It changes with time, experience and setting. |
| **Competencies** | The abilities of a person to integrate knowledge, skills and attitudes in their performance of tasks in a given context. Competencies are durable, trainable and, through the expression of behaviours, measurable. |
| **Competency-based education** | An approach to preparing [health workers] for practice that is fundamentally oriented to outcome abilities and organized according to competencies. It de emphasizes time-based training and facilitates greater accountability, flexibility and learner-centredness *(1)*. |
| **Competency framework** | An organized and structured representation of a set of interrelated and purposeful competencies *(2)*. |
| **Competent** | Descriptive of a person who has the ability to perform the designated practice activities to the defined standard. This equates to having the requisite competencies. |
| **Curriculum** | The totality of organized educational activities and environments that are designed to achieve specific learning goals. The curriculum encompasses the content of learning; the organization and sequencing of content; the learning experiences; teaching methods; the formats of assessment; and quality improvement and programmatic evaluation *(3)*. |
| **Domain** | A broad, distinguishable area of content; domains, in aggregate, constitute a general descriptive framework *(4)*. |
| **Knowledge** | The recall of specifics and universals, the recall of methods and processes, and/or the recall of a pattern, structure, or setting *(5)*. |
| **Performance (individual work performance)** | What the organization hires one to do and do well *(6)*. Performance is a function of competence, motivation and opportunity to participate or contribute *(7)*. Where competence reflects what a health worker can do, performance is what a health worker does do. |

| | |
|---|---|
| **Practice activity** | A core function of health practice comprising a group of related tasks. Practice activities are time limited, trainable and, through the performance of tasks, measurable. Individuals may be certified to perform practice activities. |
| **Proficiency** | A person's level of performance (for example, novice or expert). |
| **Skill** | A specific cognitive or motor ability that is typically developed through training and practice, and is not context specific. |
| **Standard** | The level of required proficiency. |
| **Task** | Observable unit of work within a practice activity that draws on knowledge, skills and attitudes. Tasks are time limited, trainable and measurable. |

## Health

| | |
|---|---|
| **Agency** | The power and autonomy people have to think and act for themselves. Agency can take individual and collective forms. |
| **Collaborative decision-making** | A process of engagement in which health workers and individuals, caregivers, families and communities work together to understand health issues and determine the best course of action, beyond the two-way knowledge exchange of shared decision-making *(8)*. |
| **Collaborative practice** | A process by which multiple health workers from different professional backgrounds work together with individuals, caregivers, families and communities to deliver the highest quality of care. It allows health workers to engage any individual whose skills can help achieve local health goals *(9)*. |
| **Community** | A group of people who share common interests, concerns or identities, that may or may not be spatially connected *(10)*. |
| **Discrimination** | Any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights. Discrimination also includes incitement to discriminate and harassment *(11)*. |
| **Disease and injury prevention** | Specific population-based or individual-based interventions for primary and secondary (early detection) prevention, aiming to minimize the burden of diseases and associated risk factors and to prevent or reduce the severity of bodily injuries caused by external mechanisms, such as accidents, before they occur *(12)*. |
| **Evidence-informed practice** | The integration of the best available evidence with the knowledge and considered judgements from stakeholders and experts to benefit the needs of a population *(13)*. |
| **Health** | Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity *(14)*. |

| | |
|---|---|
| **Health intervention** | An act performed for, with, on behalf of, or by an individual, family or community whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions *(15)*. |
| **Health literacy** | The cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health *(16)*. |
| **Health promotion** | The process of enabling people to increase control over their health and its determinants through health literacy efforts and multisectoral action to increase healthy behaviours *(12)*. |
| **Health worker** | Any person engaged in actions whose primary intent is to enhance health *(17)*. |
| **People-centeredness** | An approach to care that consciously adopts individuals', caregivers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized in accordance with the comprehensive needs of people rather than individual diseases and respect social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that caregivers are able to attain maximal function within a supportive working environment. People-centred care is broader than patient- and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services *(18)*. |
| **Social determinants of health** | The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels *(19)*. |
| **Stigma** | Stigma is a powerful social process of devaluing people or groups based on a real or perceived difference, such as gender, age, sexual orientation, behaviour, or ethnicity *(20)*. |
| **Universal health coverage** | 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 *(21)*. |

## References


1. Frank J, Mugroo R, Ahmad Y, Wang M, De Rossi S, Horsley T. Toward a definition of competency-based education in medicine: a systematic review of published definitions. Medical Teacher. 2010;32(8):631–7.
2. Englander R, Frank J, Carraccio C, Sherbino J, Ross S, Snell L et al. Towards a shared language for competency-based medical education. Medical Teacher. 2013;39(6):582–7.
3. Van Melle E, Frank J, Holmboe E, Dragone D, Stockley D, Sherbino J et al. A core components framework for evaluating implementation of competency-based medical education programs. Academic Medicine. 2019;94(7):1002–9.

4. Englander R, Cameron T, Ballard A, Dodge J, Bull J, Aschenbrener C. Towards a common taxonomy of competency domains for the health professions and competencies for physicians. Academic Medicine. 2013;88(8):1088–94.
5. Bloom B. Taxonomy of educational objectives, handbook: the cognitive domain. New York: David McKay; 1956.
6. Campbell J. Modeling the performance prediction problem in industrial and organizational psychology. In: Handbook of industrial and organizational psychology. California: Consulting Psychologists Press; 1990:687–732.
7. Boxall P. HR strategy and competitive advantage in the service sector. Human Resources Management Journal. 2003;13:5–10.
8. O'Grady L, Jadad A. Shifting from shared to collaborative decision making: a change in thinking and doing. Journal of Participatory Medicine. 2010;2:e13.
9. Framework for Action on Interprofessional Education and Collaborative Practice. Geneva: World Health Organization; 2010.
10. 7th Global Conference on Health Promotion, Track 1: community empowerment. Geneva: World Health Organization; 2009 (https://www.who.int/healthpromotion/conferences/7gchp/track1/en/, accessed 18 June 2021).
11. UN Committee on Economic, Social and Cultural Rights General comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), 2 July 2009, E/C.12/GC/2. Geneva: UN Committee on Economic, Social and Cultural Rights; 2009.
12. Assessment of essential public health functions: health promotion and disease prevention through population-based interventions, including action to address social determinants and health inequity. Cairo: WHO Regional Office for the Eastern Mediterranean (http://www.emro.who.int/about-who/public-health-functions/health-promotion-disease-prevention.html, accessed 18 June 2021).
13. Evidence-based methodologies for public health. Stockholm: European Centre for Disease Prevention and Control; 2011.
14. International Health Conference: Constitution of the World Health Organization, 1946. Bulletin of the World Health Organization. 2002;80(12):983–4.
15. International Classification of Health Interventions (ICHI). Geneva: World Health Organization (https://www.who.int/standards/classifications/international-classification-of-health-interventions, accessed 18 June 2021).
16. Health promotion glossary. Geneva: World Health Organization; 1998.
17. Working together for health: the world health report. Geneva: World Health Organization; 2006.
18. Framework on integrated, people-centred health services: report by the Secretariat. Sixty-ninth World Health Assembly, agenda item 16.1. Geneva: World Health Organization; 2016 (http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf, accessed 18 June 2021).
19. Social determinants of health. Geneva: World Health Organization (https://www.who.int/social_determinants/sdh_definition/en/, accessed 18 June 2021).
20. Stigma and discrimination: overview. Health Policy Project (http://www.healthpolicyproject.com/index.cfm?ID=topics-Stigma, accessed 18 June 2021).
21. Universal health coverage (UHC) fact sheet. Geneva: World Health Organization; 2019.

# Executive summary

Progress towards universal health coverage (UHC) requires strong health systems and health workers who are educated and empowered to provide the health services that populations need.

Many of the enablers of quality in UHC are system-level elements: health care facilities; medicines, devices and other technologies; information systems; financing; and the health workforce. When working in such a system of support, supervision and resources, a health worker integrating the competencies outlined in this framework into their practice is equipped to provide health care that is effective, efficient, equitable, inclusive, integrated, people centred, safe and timely. Further, it is these competencies that enable health workers to adapt to the evolving demands of health practice, acquire new responsibilities, and integrate new knowledge into their practice.

The goal of this Global Competency Framework for UHC is to guide the standards for education and practice for health workers in primary care so they are fully aligned with efforts to achieve UHC. Competencies are the abilities of health workers to integrate knowledge, skills and attitudes in their practice, demonstrated through behaviours. The competencies specified in this framework, and the behaviours that demonstrate them, are the requisite competencies for quality in UHC.

For further detail about the development of these competencies, and how to integrate the competencies and behaviours into the design, delivery and assessment of competency-based education programmes, please refer to the full document: *Global Competency and Outcomes Framework for Universal Health Coverage (UHC) (1)*. The Global Competency and Outcomes Framework for UHC will be accompanied by service-specific modules that describe individual health services in terms of their component practice activities. These modules will be published incrementally to aid the contextualization of curricula according to population health needs.

# 1. Using the Global Competency Framework for UHC

## 1.1 Competency-based approach to education rooted in population health needs

The Lancet Commission *(2)*, amongst others, has called for a competency-based outcomes approach to education and training that is rooted in health and health system needs. Competency-based education (CBE) is an outcomes-based approach to learning that situates knowledge and skills in the context of practice and the health services provided, and emphasizes the mastery of learning. Rather than an exclusive focus on the services to be provided, and the acquisition of the underpinning knowledge, skills and attitudes, competencies are the abilities of the health worker to integrate and apply the necessary knowledge, skills and attitudes in the provision of services, as required for the context. This requires a holistic approach to the specification of competencies and outcomes, and the design and delivery of education programmes to enable learners to achieve those outcomes. This shift in emphasis enables better preparedness for practice, ensures quality of care, and enables development of a more resilient and adaptable health workforce.

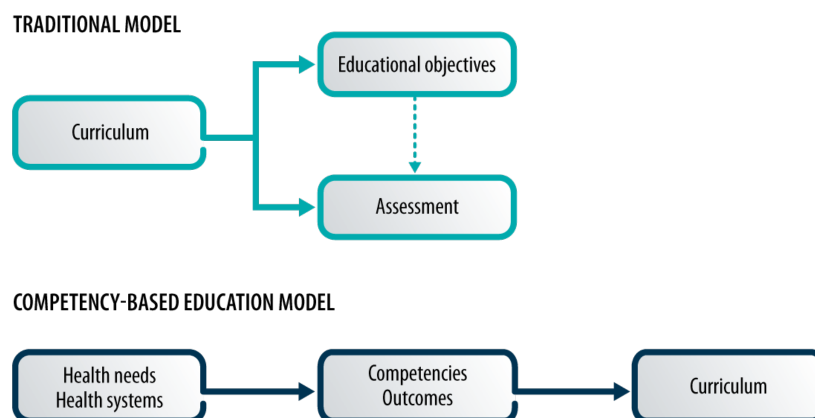
The learner-centred approach within CBE, and the focus on outcomes achieved rather than the process or duration of learning, also offers the potential to promote equity and inclusion through flexible education pathways *(3)*. A gender and equity lens in health worker education can have a long-lasting transformative effect on both employment and health outcomes.

CBE has the potential to improve the health of the community only in so far as context-specific health issues are used to determine the desired competencies *(2)*. Developing competency-based curricula to meet population health needs is a process that begins first by identifying what those population health needs are; then by defining the outcomes needed to meet those needs; and finally by tailoring the curriculum to meet those outcomes. Figure 1 depicts the shift from traditional models of education that focus on the curriculum content, and competence measured through the acquisition of knowledge, skills and attitudes and completed time in training. CBE models of education, on the other hand, focus on the application of knowledge, skills and attitudes in the context of defined competencies and outcomes of the programme. Further, programme competencies and outcomes are explicitly defined in relation to health needs and health systems.

Competency-based outcomes of education requires a dual focus on the services to be provided and the competencies of the person who provides them. The outcomes of education programmes are framed in terms of what the health worker will do (practice activities) and how they will do it (competencies).

- Practice activities are the responsibilities for health services that a learner will have. Practice activities describe a group of related tasks with a common purpose, such as provision of a procedure or care coordination, with the specification of limitations and level of supervision. This holistic approach to defining outcomes moves away from a checklist of practice, and acknowledges the unpredictable nature of health care and the different contexts and challenges that might be encountered. Practice activities and their component tasks can be observed from start to finish. Practice activities can be used to differentiate between role responsibilities within a team and to define job descriptions, scopes of practice, certification or qualifications.

**Fig. 1. Comparison of traditional models of education and CBE**




*Source:* Adapted from Frenk et alt *(2)*.

- Competencies are a person's abilities to integrate knowledge, skills and attitudes in their performance of tasks. Competencies are interrelated and interdependent. This means that they cannot be learned, observed or assessed in isolation, but only in the context of practice. Competencies are durable, trainable and measurable through behaviours. Further, these competencies enable the range of performance, and are not specific to an individual task or practice activity. As such, a given situation might require the integration of multiple competencies, and every competency has the potential to underpin the performance of any practice activities within an individual's role and responsibility. Competencies are what a person brings to their practice; they are not certifiable as a stand-alone unit of certification or regulated activity, only in the context of practice activities.

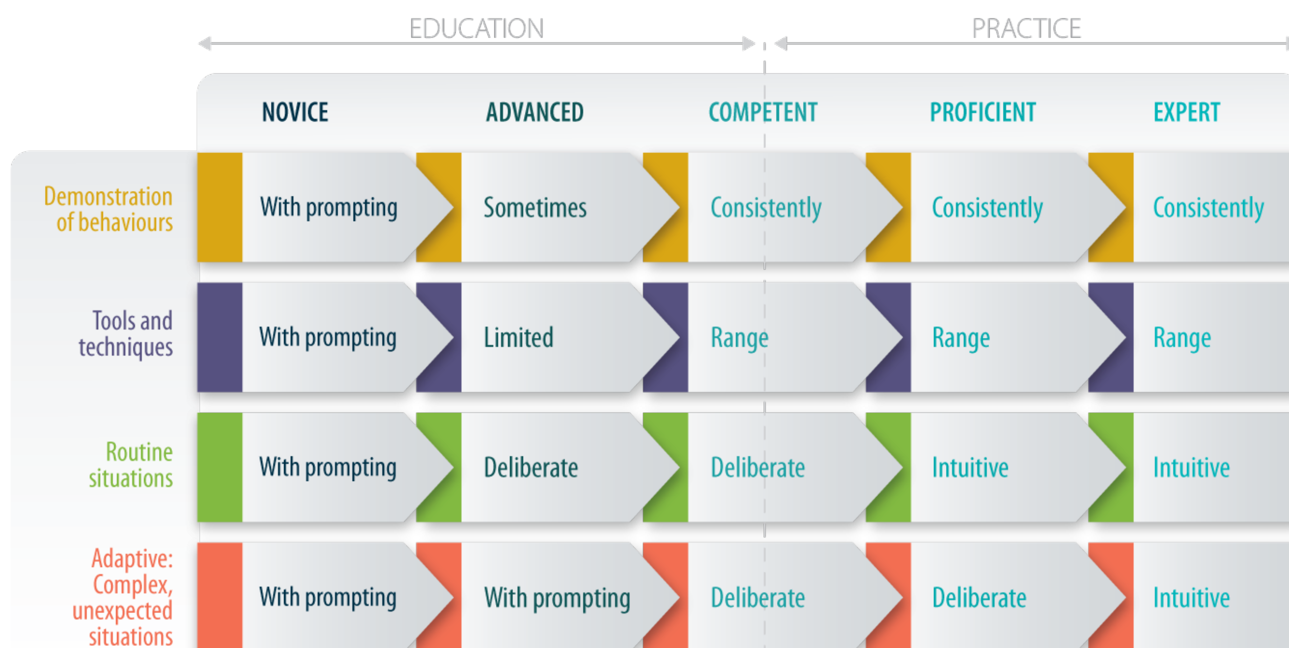
Competence is a holistic measure of the performance of practice activities to the standard defined in terms of behaviours; hence, competence is the integration and application of knowledge, skills and attitudes to practice. CBE is a deliberate and intentional specification of performance standards in terms of the requisite competencies and the behaviours that demonstrate them. The two types of outcomes (practice activities and competencies) of education and training programmes must be considered together when determining a person's proficiency, and determining progression decisions. This approach build upon efforts among educationalists to clarify and conceptualize competencies in relation to (and thus distinct from) the performance of work *(4–7)*, in particular the work of the International Competency-Based Medical Education collaborators *(8, 9)*.

## 1.2 Specification of competency-based practice standards

This Global Competency Framework for Universal Health Coverage (UHC) is a foundational tool to be adopted and adapted by educators and regulators. The behaviours defined in this framework highlight the different components of a competency expected for quality in UHC services. Additional specification is required for these to be used as a measure of performance relevant to the practice activity, namely the tools, techniques, situations likely to be encountered, settings (for example facility, community, conflict zones), people with whom interaction is likely, level of responsibility and level of supervision.

All health workers draw on their competencies in their practice; however, the manner in which they integrate them will vary according to the complexity and autonomy of the practice activities. For example, all health workers need to be able to make decisions effectively at different levels, from using a decision-making aid to making ethically challenging decisions about the allocation of resources. In these situations, the decision-making competency may be the same, but the context and level of responsibility mean that the

**Fig. 2. Demonstration of behaviours aligned with the Dreyfus and Dreyfus (1986) model of skills acquisition**




competency-based standards are very different. The standards may differ depending on the stage of training or responsibility in practice, as defined by the practice activities.

A competent health worker consistently integrates the required competencies into their practice. As health workers increase their proficiency (level of performance), behaviours become more intuitive and less deliberate; these behavioural nuances are difficult to assess. Proficiency can continue to increase in practice with time, experience or learning; similarly, a person may lose their competence without experience or practice. Relating the learner's acquisition of competencies to the Dreyfus and Dreyfus (1986) model of skills acquisition *(10)*, descriptors can be used to illustrate competence development in the context of practice activities (Figure 2).

## 1.3 Competency-based approach to the design and delivery of education programmes

The outcomes of pre-service education programmes should reflect what the learner does in practice (practice activities encompassing the performance of tasks) and the standards to which these are performed (competencies demonstrated through behaviours). When designing a curriculum, it is common and advisable to break complex competencies and outcomes into sets of knowledge and skills, ensuring mastery of each before progressing to the application and assessment of competence in context.

The focus of CBE is mastery of the learning outcomes of the programmes, defined in terms of the application of knowledge, skills, attitudes and behaviours to practice. Figure 3 illustrates how knowledge, skills and attitudes underpin both competencies (and behaviours) and practice activities (encompassing tasks).

Knowledge, skills and attitudes are developed interdependently. It cannot be assumed that learners will intuitively respond to different situations; effective behaviours are an integral part of effective performance of tasks, and the different contexts, and expected performance in those contexts, warrants explicit focus in curricula. The principles of CBE consider that effective behaviours are not learned in isolation, but in the context of the tasks and situations for real-world practice. Achieving the full potential of CBE requires more

**Fig. 3. Relationship between competencies and practice activities, and their underpinning of knowledge, skills and attitudes**

than the articulation of competencies in a framework; it also requires a range of pedagogies, educational techniques, learning experiences and assessment to support learners to develop the requisite knowledge, skills, attitudes and behaviours and to achieve the defined outcomes. The principles of CBE, summarized in Table 1, should guide competency-based curricula (re)design and assessment.

**Table 1. Principles of CBE**

| Variable | Traditional education | Competency-based education |
|---|---|---|
| **Driving force for curriculum** | Content | Outcome |
| **Goal of educational encounter** | Acquisition of knowledge, skills and attitudes | Application of knowledge, skills and attitudes to performance |
| **Driving force for progress** | Teacher | Learner |
| **Path of learning** | Hierarchical (teacher –> student) | Non-hierarchical (teacher <–> learner) |
| **Responsibility for content** | Teacher | Learner, teacher, institution and governing body together |
| **Organization of content** | Preclinical and clinical phases | Modular, progressive sequencing |
| **Typical assessment tool** | Single measure | Multiple measures ("evaluation portfolio") |
| **Assessment tools** | Proxy | Authentic (mimics real tasks of health care) |
| **Setting for evaluation** | Gestalt approach (competence determined as the sum of the parts) | Direct observation (competence determined as the integrated whole, more than the sum of the parts) |
| **Evaluation** | Norm-referenced | Criterion-referenced standards |
| **Timing of assessment** | End of programme (summative) | Regular, continuous (formative) as well as end of programme and continuous (summative) |
| **Programme completion** | Fixed time (independent of need) | Variable time (adapted to need) |

*Source:* Adapted from Van Melle et al. *(4)* and Carraccio et al. *(11)*.

## 1.4 Incorporation into individual health worker learning and professional behaviour

The competencies in this framework describe good practice that should be incorporated into all aspects of health care. A competent health worker consistently integrates the required competencies into their practice at the defined standard. Even where these competencies are not incorporated into regulated standards, all health workers can strive to integrate them into their practice. Managers, educators and health workers themselves can use this framework to identify areas where further training or a change in behaviours may be necessary. This might involve identifying tools or approaches that embody the different behaviours, such as evidence-based guidelines or clarifying ways of working within teams, or reflecting on why particular behaviours are essential for the provision of quality in health services.

# 2. Competencies for universal health coverage: overview

The Global Competency Framework for UHC identifies 24 competencies organized into six domains. Although presented as a list, the competencies are interrelated and interdependent.

## Domain I: People-centredness

*Competencies related to the provision of health services that incorporate perspectives of individuals, caregivers, families and communities as participants in and beneficiaries of health systems*

1. Places people at the centre of all practice
2. Promotes individual and community agency
3. Provides culturally sensitive, respectful and compassionate care
4. Incorporates a holistic approach to health

## Domain II: Decision-making

*Competencies related to the approach to decision-making*

5. Takes an adaptive, collaborative and rigorous approach to decision-making
6. Incorporates a systems approach to decision-making
7. Takes a solutions-oriented approach to problem solving
8. Adapts to unexpected or changing situations

## Domain III: Communication

*Competencies related to effective communication*

9. Proactively manages interactions with others
10. Adapts communication to the goals, needs, urgency and sensitivity of the interaction
11. Listens actively and attentively
12. Conveys information purposefully
13. Manages information sharing and documentation

## Domain IV: Collaboration

*Competencies related to the practice philosophy of teamwork*

14. Engages in collaborative practice
15. Builds and maintains trusting partnerships
16. Learns from, with and about others
17. Constructively manages tensions and conflicts

## Domain V: Evidence-informed practice

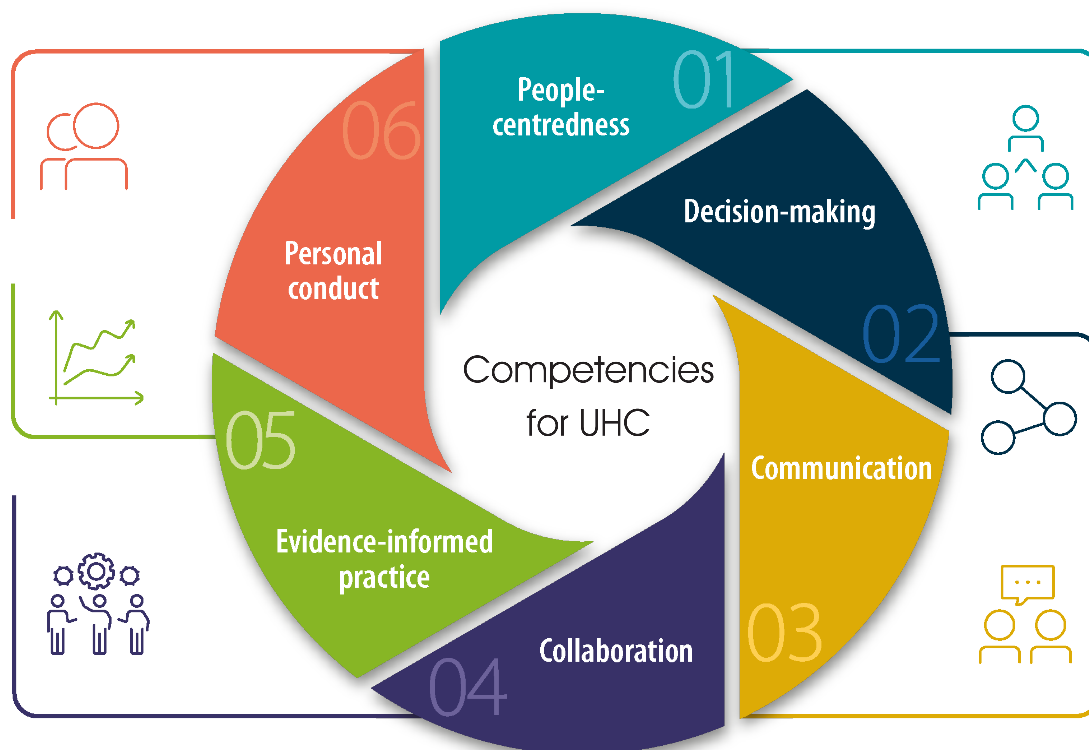
*Competencies related to the generation of evidence and information and their integration into practice*

18. Applies the principles of evidence-informed practice
19. Assesses data and information from a range of sources
20. Contributes to a culture of safety and continuous quality improvement

## Domain VI: Personal conduct

*Competencies related to self-governed behaviours*

21. Works within the limits of competence and scope of practice
22. Demonstrates high standards of ethical conduct
23. Engages in lifelong learning and reflective practice
24. Manages own health and well-being



# 3. Competencies and behaviours for UHC

## Domain I: People-centredness

All health workers have a role in the provision of health services that put people and communities, not diseases, at the centre of health systems and empower people to take charge of their own health rather than being passive recipients of health *(13)*. This requires health workers to consciously adopt an approach to their health practice that incorporates the perspectives of individuals, families and communities as participants in and beneficiaries of trusted health systems. Whilst many of the enabling factors for the provision of integrated people-centred health services are system based, the competencies in this domain, and the behaviours through which these competencies can be demonstrated in practice, reflect the capacity of all health workers to provide integrated people-centred health services. These competencies are relevant to interactions with all people encountered through health services.

**Competency 1: Places people at the centre of all practice**

| | | |
|---|---|---|
| Behaviours | 1.1 | Provides the best possible health care that supports an approach to health services that is effective, equitable, efficient, inclusive, integrated, people centred, safe and timely |
| | 1.2 | Adapts practice to the individual, family and community, including their physical, cognitive, cultural, emotional, linguistic, health literacy and sensory needs and other influences on their engagement with health services |

**Competency 2: Promotes individual and community agency**

| | | |
|---|---|---|
| Behaviours | 2.1 | Supports people to develop their health literacy |
| | 2.2 | Demonstrates respect for the autonomy, goals, perspectives, preferences, priorities and rights of individuals, caregivers, families and communities |
| | 2.3 | Supports people to develop strategies or access tools to manage their own health and well-being |

**Competency 3: Provides culturally sensitive, respectful and compassionate care**

| | | |
|---|---|---|
| Behaviours | 3.1 | Demonstrates compassion, empathy and respect for all people[1] |
| | 3.2 | Adopts an approach to practice that is non-blaming, non-discriminatory, non-judgemental and non-stigmatizing |
| | 3.3 | Maintains self-awareness around own beliefs, biases, emotional responses and values |
| | 3.4 | Demonstrates cultural sensitivity |
| | 3.5 | Embraces individual differences and cultural diversity |
| | 3.6 | Challenges the causes and consequences of discrimination, exclusion, prejudice, stigma and other barriers to accessing and utilizing health services |

**Competency 4: Incorporates a holistic approach to health**

| | | |
|---|---|---|
| Behaviours | 4.1 | Supports people to challenge or address their economic, environmental, political and social determinants of health |
| | 4.2 | Supports people to manage their health within health system constraints and their determinants of health |
| | 4.3 | Incorporates health promotion and disability, disease and injury prevention into interactions |
| | 4.4 | Supports individuals, caregivers, families and communities to adopt healthy behaviours |
| | 4.5 | Contributes to protecting vulnerable populations |

[1] "All people" signifies irrespective of age, asylum or migration status, criminal record, culture, disability, economic status, ethnicity, gender identity and expression, health literacy, health status, language, nationality, race, religion, sex, sexual orientation, treatment adherence, vulnerability to ill-health or other characteristic.

## Domain II: Decision-making

All actions taken by a health worker in the course of their practice involve decisions with consequences for the health of others, the use of resources, or others' experiences of health services. Clinical decision-making involves interpreting evidence for a context using judgement on relevance, timeliness, resource implications and others' needs and preferences, sometimes with incomplete information. The complexity of the decisions to be made, the implications of those decisions, and the level of judgement vary according to role and responsibility. However, to provide quality health services, all health workers require competencies to make effective and timely decisions in a range of circumstances, the ability to use decision-making tools and aids, and awareness of the decisions they can make alone or in consultation with others.

| Competency 5: Takes an adaptive, collaborative and rigorous approach to decision-making | | |
|---|---|---|
| Behaviours | 5.1 | Promotes collaborative decision-making |
| | 5.2 | Seeks information and evidence from a range of sources when approaching decision-making |
| | 5.3 | Approaches decisions analytically and methodically |
| | 5.4 | Adapts the approach to decision-making that reflects the complexity, urgency and consequences of decisions |
| | 5.5 | Demonstrates critical thinking to reach decisions that are well reasoned, ethical, evidence informed, feasible, timely and based on the best available information |

| Competency 6: Incorporates a systems approach to decision-making | | |
|---|---|---|
| Behaviours | 6.1 | Uses physical, human and financial resources efficiently |
| | 6.2 | Avoids the overuse or misuse of resources |
| | 6.3 | Organizes own time and workload effectively |
| | 6.4 | Takes responsibility for own decisions and their consequences |

| Competency 7: Takes a solutions-oriented approach to problem-solving | | |
|---|---|---|
| Behaviours | 7.1 | Takes initiative to mitigate anticipated problems |
| | 7.2 | Focuses on solutions, end goals and results |
| | 7.3 | Creates pragmatic solutions to identified problems |

| Competency 8: Adapts to unexpected or changing situations | | |
|---|---|---|
| Behaviours | 8.1 | Demonstrates flexibility and patience |
| | 8.2 | Adjusts priorities to respond to changing situations and demands |
| | 8.3 | Demonstrates a calm demeanour under pressure |

## Domain III: Communication

Communication is fundamental to how health workers guide, inform, support and collaborate with the individuals, caregivers, families and communities for whom they provide health services, as well as with other members of the health team. Effective communication is a process that requires health workers to manage their own verbal and non-verbal communication, respond to the verbal and non-verbal communications of others and complete documentation. Not all communication takes place face to face or in writing, and different situations may require health workers to communicate using augmentative and alternative communication tools and methods, telephones, interpreters and digital technologies.

**Competency 9: Proactively manages interactions with others**

Behaviours

- 9.1 Clarifies the communication goals[1] for an interaction
- 9.2 Identifies when and how to initiate, conduct and close an interaction
- 9.3 Manages communication barriers due to cognitive, physical or sensory impairment, culture, developmental stage, geography or language
- 9.4 Supports others to communicate for themselves
- 9.5 Manages the physical environment for interactions considering the impact of comfort, privacy, noise, space and temperature

**Competency 10: Adapts communication to the goals, needs, urgency and sensitivity of the interaction**

Behaviours

- 10.1 Adapts the style, language and method of communication to the interaction
- 10.2 Maintains an approach to communication that is characterized by calmness, compassion, empathy, respect, sensitivity and tact
- 10.3 Seeks to mitigate the impact of own beliefs, biases, emotional responses, opinions and values on verbal and non-verbal communication
- 10.4 Uses relevant abbreviations, language and terminology, translating complex and clinical content into lay terms as necessary
- 10.5 Uses a range of verbal, non-verbal, visual, written and digital communication tools and techniques

**Competency 11: Listens actively and attentively**

Behaviours

- 11.1 Uses a range of non-verbal cues and verbal affirmations
- 11.2 Supports others to ask questions and openly express experiences, feelings, ideas and opinions
- 11.3 Responds sensitively to what others express

**Competency 12: Conveys information purposefully**

Behaviours

- 12.1 Provides relevant, accurate and complete information
- 12.2 Presents information clearly, coherently, concisely and organized logically
- 12.3 Differentiates between information as facts, context-specific evidence, opinion and misinformation
- 12.4 Expresses own opinions and perspectives with clarity, confidence and respect
- 12.5 Adopts strategies that encourage a common understanding of information and decisions

**Competency 13: Manages information sharing and documentation**

Behaviours

- 13.1 Uses a range of health-related information management tools, including individual health records
- 13.2 Keeps people informed about health risks and relevant aspects of their health care
- 13.3 Shares information with relevant others in a timely manner
- 13.4 Complies with ethical and legal requirements for obtaining, recording, sharing, retaining and destroying information acquired in an occupational capacity

[1] Communication goals describe the desired outcomes of the interaction, for example, conveying or receiving information, persuading, building trust or providing support, and the urgency.

## Domain IV: Collaboration

The philosophy of team work underpins health practice *(6)*, involving collaboration with other health workers, intersectoral collaboration, and collaboration with individuals, caregivers, families and populations as informed members of the health team. Some health workers will have responsibilities to lead teams and may take a more formal role to facilitate teams, as explored through the practice activities; but all health workers are part of multiple formal and informal teams in the course of their practice.

| Competency 14: Engages in collaborative practice | | |
|---|---|---|
| Behaviours | 14.1 | Engages with others across cultural, geographical, organizational and sectoral boundaries, and with individuals, caregivers, families and communities, as partners |
| | 14.2 | Jointly negotiates roles and responsibilities to maximize strengths within a team |
| | 14.3 | Fulfils agreed ways of working within the health team |
| | 14.4 | Enables others to make their contribution to a team |
| | 14.5 | Celebrates shared outcomes, goals and values |

| Competency 15: Builds and maintains trusting partnerships | | |
|---|---|---|
| Behaviours | 15.1 | Maintains constructive and collaborative working relationships with others, whether or not a formal team exists |
| | 15.2 | Strives to develop a positive rapport with others characterized by respect, support and trust |
| | 15.3 | Maintains ethical boundaries with other members of the health team |
| | 15.4 | Minimizes the impact of hierarchical differences on health outcomes |

| Competency 16: Learns from, with and about others[1] | | |
|---|---|---|
| Behaviours | 16.1 | Demonstrates willingness to learn from others' experiences of the health system, health conditions and lived environment |
| | 16.2 | Seeks constructive, sensitive and timely feedback, support and advice |
| | 16.3 | Provides constructive, sensitive and timely feedback, support and advice |
| | 16.4 | Learns from interactions with others and feedback processes |
| | 16.5 | Engages in opportunities to improve collaboration within and between teams |

| Competency 17: Constructively manages tensions and conflicts | | |
|---|---|---|
| Behaviours | 17.1 | Anticipates, identifies, acts upon and learns from tensions or potential areas of conflict |
| | 17.2 | Focuses on the sources of tensions rather than arising conflicts |
| | 17.3 | Supports a blame-free environment in which one is safe to question and seek support and guidance |
| | 17.4 | Considers different perspectives when seeking compromise, consensus or a decision |
| | 17.5 | Uses diplomacy to mediate, negotiate or persuade |
| | 17.6 | Takes positive action to avoid and dispel abuse, harassment or other disruptive behaviours |

[1] Others includes individuals, families, caregivers, communities and other health workers.

## Domain V: Evidence-informed practice

Evidence-informed practice enables individuals and communities to receive the best possible care regardless of where they live, improves quality and safety, and contributes to better health outcomes *(14)*. Health workers routinely acquire and interpret high volumes of data, information and evidence from individuals, caregivers, families, communities and other health workers, as well as from experts, journals, guidelines, government, websites and media. This information varies in relevance, detail and accuracy. In the health context, evidence is usually high-quality information gained from research, and is therefore more predictable and reliable. Whilst all evidence is information, not all information is evidence. To provide the best possible health care, service provision must be evidence informed. The ways through which an individual health worker implements evidence-informed practice depends on their role and responsibility: from strictly following evidence-based protocols and guidelines, to integrating evidence with experience and individuals' values according to the circumstances. This domain focuses on the competencies related to the application of the best available evidence from scientific or published research studies to practice; the appraisal and integration of data and information; and the role of the health worker in generating and using information and adapting it to guide quality of care, safety and improvement efforts in the local context.

| **Competency 18: Applies the principles of evidence-informed practice** | |
|---|---|
| Behaviours | 18.1 Maintains awareness of evidence-informed practice |
| | 18.2 Integrates current best available evidence into practice |
| | 18.3 Promotes evidence-informed practice amongst colleagues |
| | 18.4 Participates in the generation and application of evidence |

| **Competency 19: Assesses data and information from a range of sources** | |
|---|---|
| Behaviours | 19.1 Identifies the need for additional data and information |
| | 19.2 Promotes access to data, information and evidence |
| | 19.3 Seeks data, information and evidence from a range of sources |
| | 19.4 Critically appraises the limitations, quality, relevance and significance of data, information and evidence |
| | 19.5 Manages the risks of harm from misinformation |

| **Competency 20: Contributes to a culture of safety and continuous quality improvement** | |
|---|---|
| Behaviours | 20.1 Adheres to safety protocols that avoid adverse events, health care errors, and incidents of harm and unsafe practice |
| | 20.2 Learns from what works and what has not gone well |
| | 20.3 Offers suggestions for improvement to address identified problems |
| | 20.4 Participates in quality measurement and continuous quality improvement processes |

## Domain VI: Personal conduct

The way that health workers conduct themselves in the course of their practice has implications for safety and quality in health care and fostering trust. The competencies in this domain describe the ethical principles that guide a health worker in their day-to-day practice and in a range of situations, and their rights and responsibilities in managing their own health, engaging in lifelong learning and working within a regulated scope of practice. Health workers can take a proactive role in identifying and resolving challenges when issues do arise, ultimately to ensure their own health, well-being and competence, which in turn serves to benefit the individuals and community they serve.

**Competency 21: Works within the limits of competence and scope of practice**

| | |
|---|---|
| **Behaviours** | 21.1 Maintains awareness of own competence and scope of practice |
| | 21.2 Adheres to the duties, obligations and codes of conduct defined by occupational standards, legal regulations and organizational procedures |
| | 21.3 Seeks guidance when encountering situations beyond competence or scope of practice |

**Competency 22: Demonstrates high standards of ethical conduct**

| | |
|---|---|
| **Behaviours** | 22.1 Acts with honesty, integrity and transparency |
| | 22.2 Upholds legal and ethical principles, including capacity, confidentiality, consent, conflict of interest, duty of care, dignity, privacy and safeguarding |
| | 22.3 Consults with others in situations with ethical implications |
| | 22.4 Refuses individual gifts or other forms of influence intended to coerce or invite personal favour |

**Competency 23: Engages in lifelong learning and reflective practice**

| | |
|---|---|
| **Behaviours** | 23.1 Seeks and engages in continuous formal and informal learning linked to current and emerging practice responsibilities |
| | 23.2 Engages in self-learning and reflective practice |
| | 23.3 Seeks to address any negative impact of own attitudes, behaviours and gaps in competence or practice |

**Competency 24: Manages own health and well-being**

| | |
|---|---|
| **Behaviours** | 24.1 Monitors own mental, physical and social health and well-being |
| | 24.2 Uses a range of strategies to manage fatigue, ill-health, stress and the impact of exposure to distressing and emergency situations |
| | 24.3 Seeks help or support where needed for own health and well-being |
| | 24.4 Engages in self-care practices that promote emotional resilience, health and well-being |

# References


1. World Health Organization. Global Competency and Outcomes Framework for Universal Health Coverage. Geneva: World Health Organization; 2022.
2. Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010;376:1923–58. doi:10.1016/s0140-6736(10)61854-5.
3. Newman C, Ng C, Pacqué-Margolis S, Frymus D. Integration of gender-transformative interventions into health professional education reform for the 21st century: implications of an expert review. Human Resources for Health. 2016;14:14.
4. Van Melle E, Frank J, Holmboe E, Dragone D, Stockley D, Sherbino J et al. A core components framework for evaluating implementation of competency-based medical education programs. Academic Medicine. 2019;94(7):1002–9.
5. Mills JA, Middleton J, Schafer A, Fitzpatrick S, Short S, Cieza A. Proposing a re conceptualisation of competency framework terminology for health: a scoping review. Human Resources for Health. 2020;18:15.
6. Frank J, Snell L, Sherbino J. CanMEDS 2015 Physician Competency Framework. Ottawa: Royal College of Physicians and Surgeons of Canada; 2015.
7. ten Cate O. Entrustability of professional activities and competency-based curriculum. Medical Education. 2005;39(12):1176–7.
8. Frank J, Snell L, ten Cate O, Holmboe E, Carraccio C, Swing S et al. Competency-based medical education: theory to practice. Medical Teacher. 2010;32(8):638–45.
9. Englander R, Frank J, Carraccio C, Sherbino J, Ross S, Snell L et al. Towards a shared language for competency-based medical education. Medical Teacher. 2013;39(6):582–7.
10. Dreyfus H, Dreyfus S. Mind over machine: the power of human intuition and expertise in the age of the computer. Oxford: Basil Blackwell; 1986.
11. Carraccio C, Wolfsthal S, Englander R, Ferentz K, Martin C. Shifting paradigms: from Flexner to competencies. Academic Medicine. 2002;77(5):361–7.
12. Framework on integrated, people-centred health services: report by the Secretariat. Sixty-ninth World Health Assembly, agenda item 16.1. Geneva: World Health Organization; 2016 (http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf, accessed 18 June 2021).
13. World Health Organization, Organisation for Economic Co-operation and Development, and World Bank. Delivering quality health services: a global imperative for universal health coverage. Geneva: World Health Organization; 2018.
14. Facilitating evidence-based practice in nursing and midwifery in the WHO European Region. Copenhagen: World Health Organization Regional Office for Europe; 2017.

Health Workforce Department
World Health Organization
20 Avenue Appia
CH 1211 Geneva 27, Switzerland
www.who.int/hrh