

Unit 7

Improving outcomes with community health workers

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Cover photo: A village health worker listens carefully to a patient in rural Malawi



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“Community health workers are the most valuable component of a strategy to extend primary health services to rural communities.”

– Didi Bertrand Farmer, Director of the Community Health Program, Inshuti Mu Buzima (PIH Rwanda)

INTRODUCTION

Community health workers (CHWs) around the world are men and women who work to improve the health outcomes and general well-being of their fellow community members. The 1978 Declaration of Alma-Ata described CHWs as a major vehicle for the advancement of primary health care in areas with limited resources, stating, “The people have the right and duty to participate individually and collectively in the planning and implementation of health care.”¹ CHWs provide a vital link between community members and health centers and hospitals; they extend the reach of the clinic by supporting disease prevention, treatment, and case-finding efforts. They also amplify the voice of the community to the medical establishment by informing doctors, nurses, and other health professionals of the needs and conditions in the community that affect health. Typically, CHWs fill an important gap, connecting particularly poor communities and marginalized populations, such as orphans and vulnerable children, to health care and other social services, such as access to food, clean water, jobs, education, and housing.

The concept of CHWs is not new, but dates back to over 50 years ago (a well-known example is that of the “Barefoot Doctors” in China in the 1950s). In Haiti, where PIH’s CHW program originated, they are called *accompagnateurs*, to emphasize the importance of

¹ Declaration of Alma-Ata. (1978). *International Conference on Primary Health Care*, Alma-Ata, USSR. Retrieved online at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf, here quoted from Palazuelos, D. (2010). Community participation: Who participates? Who decides? *Harvard College Global Health Review*, 1(2):45. Retrieved online at: <http://issuu.com/hcghreview/docs/hcghrwinter2010>.

accompanying community members in their journey through sickness and back to health.² This unit explores some of the key components and lessons learned from designing and implementing CHW programs at PIH-supported sites within national primary healthcare systems. In some settings where we work, CHWs are trained to offer simple diagnoses and treatment, to refer community members to health facilities, and to offer social support. In other settings, their mandate may focus on health prevention or education. Regardless of the scope of CHWs' interventions, however, each CHW program responds to the unique context and needs of the country in which it is located. In this unit, we focus on the operational aspects of recruitment, compensation, and supervision. *Unit 6: Improving programs through training* provides an overview of how PIH designs training programs for CHWs.

1. THE BASICS OF A CHW PROGRAM

When planning to implement or support a community health worker program, you may find it helpful to begin by considering:

1. What are the specific goals of the CHW program?
2. How will the CHW program connect to existing programs and to other stakeholders, including the national government?
3. How will CHWs be recruited from the community? (See *Section 3, Recruiting CHWs* for more on recruitment and selection.)
4. What incentives will CHWs receive, for example, payment, tools to do their jobs better, and ongoing training and education?
5. What are CHWs' roles and responsibilities?
6. How will CHWs be trained and supervised?
7. What tasks are expected of CHWs?
8. What main outcomes will the program focus on?
9. How will these outcomes be measured to evaluate program performance and share these data with current and prospective funders? (See *Unit 12: Using monitoring and evaluation for action* for more on measuring impact.)
10. How much funding is needed to initiate and sustain the program?

First, it is important to determine whether your community health worker program will function through the public sector, private sector, or a combination of both. The public sector includes services that are governed by the state only, for example, public roads or primary education. The private sector is the part of an economy that is run mainly for private profits and is not governed by the state (such as a hospital that is owned by a for-profit company

² Community health workers have different titles in different settings throughout the world and at PIH-supported sites. Throughout this unit, we will refer to all community members who provide this type of accompaniment to patients struggling with poverty and disease as community health workers.

or a nonprofit organization that is privately funded through payment for medical services by patients themselves). An example of functioning in both private and public systems would be the case of a nonprofit organization (NGO) that pays CHWs to work within a government structure.

PIH pays CHWs to work in the public sector because we believe that a vital public sector is the best way to bring health care to the poor. While nongovernmental organizations (NGOs) have a valuable role to play in developing new approaches to treating disease, successful models must be implemented and expanded through the public sector to ensure universal and sustained access. Rather than establish parallel systems, PIH works to strengthen and complement existing public health infrastructure. However, there are advantages and disadvantages to working in both systems. Within the public sector, there is often the opportunity for broader scale up and implementation. For instance, the government may have developed a vision, need support implementing it, and your program may demonstrate the expertise needed to help meet that goal. When working within the private sector, advantages can include more control over the scope or mandate of the CHW program than if working within the public sector. However, any private sector program should ideally be integrated within the national primary healthcare system so that it complements and strengthens the public sector CHW program, if one exists.

Understanding the cultural, political, and historical context is fundamental to successfully implementing a CHW program. (See *Unit 1: Learning about the local context* for more information.) Before you initiate a new CHW program, identify what comparable programs are already in place. The Ministry of Health (MOH) or other NGOs may have a similar program, and harmonizing a new program with existing efforts is better than building a parallel system. Learn about hiring practices, roles, payment, and as many other details as possible.

Determine the mandate of the CHW program in collaboration with the MOH or other participating organizations. Since funding limitations often guide programming in the early years of an organization's life, most small organizations begin by using CHWs for a disease-specific intervention. Your program may choose to limit the role of CHWs to addressing particular health problems in the community, such as HIV, TB, or malaria. Alternatively, you may choose to address the needs of particularly vulnerable segments of the population, such as pregnant women.

Your program may be a source of health education and prevention rather than diagnosis or referral. Whatever you choose, it is important to ensure that you are able to support CHWs financially and with adequate supervision and training. Determine the geographic scope of the intervention by identifying key communities that will receive the support of the CHW program, and establishing the ratio of CHWs to population served. This will likely vary from country to country, especially given different rural population densities across



Figure 1: A CHW provides directly observed therapy to a patient in Rwanda
Photo: Adam Bacher

countries. For example, a CHW may be able to visit many more households per day in a densely populated rural area than would be possible in a sparsely populated area.³

After determining the scope of your intervention, select the CHWs themselves. If possible, the cadre that will supervise the CHWs should participate in the selection process. Depending on the national context, CHWs may be selected either by the program or by the local community. Basic criteria of selection include minimum age and education level, gender, and standing within the community. Additionally, the national context will in part determine the compensation structure; ideally, all CHWs should be compensated fairly for their work, but this is not universally implemented. Often, national CHW programs struggle to support CHWs financially, or support them through cooperatives or other collective means of compensation. Whatever your program's philosophy, the compensation process is a key issue that needs to be addressed in advance with other stakeholders when designing your program.

Once you have determined the scope of your program, and have recruited CHWs, the next step is to design a training and supervision system. Only when they are appropriately trained, compensated, and professionally supported can CHWs properly carry out their work. There are many considerations when planning and implementing a successful training program. (See *Unit 6: Improving programs through training*.) A rigorous training program that is aligned with national protocols is fundamental to a successful CHW program. (See *Section 1.2, Budgeting for a CHW program*.) It should use standardized and evidence-based (when applicable) training materials and methodologies appropriate to adult learners. Identify the key topics for training as well as ensure ongoing CHW support and education. Additionally, a strong supervision system—involving clear expectations and a routine supervision schedule by respected and compensated CHW supervisors—ensures that the structure you have envisioned is appropriately implemented. Monitoring and evaluation tools are essential to a successful CHW program, and can be utilized through the supervision structure. Data regarding the program's effectiveness contribute directly to requests for funding, training plans, and subsequent modifications in the CHW program.

³ The Earth Institute. (n.d.). *One Million Community Health Workers: Technical Task Force Report*. Retrieved online from: http://millenniumvillages.org/files/2011/06/1mCHW_TechnicalTaskForceReport.pdf.



PIH NOTE

In 2005, at the invitation of the Rwandan Ministry of Health, PIH began to support the Rwandan “binôme” system, in which each village had two community health workers. From this beginning, PIH’s support of Rwanda’s national system has taken many forms. It began with accompaniment, in which CHWs practiced directly observed therapy (DOT), ensuring that community members with HIV or tuberculosis took their medications appropriately. The scope of CHWs’ work has since broadened to include primary health care and maternal health activities. CHWs in PIH-supported areas receive monthly trainings in these expanded health topics as well as an introductory training in DOT. PIH also supplements CHWs’ compensation; the Rwandan government compensates CHWs through cooperatives, and PIH provides individual payments. Eventually, the CHW systems in PIH catchment areas will be integrated with Rwanda’s national CHW program for a unified community health approach. To integrate and unify the two programs in a progressive, ongoing manner, we identified the following priority aims that would allow us to meet our goals:

- *train multi-disciplinary CHWs who can manage a range of interventions beyond care and treatment for HIV and TB, including reproductive health, family planning, malaria, vaccination, nutrition, hygiene, and sanitation, among other issues*
- *ensure an adequate number of CHWs to address the workload (based on number of households in caseload, distances between households, and severity of conditions)*
- *provide standardized trainings (including refresher trainings)*
- *offer systematic support and supervision*
- *foster respect for CHWs within the community*
- *provide performance-based compensation*
- *harmonize the network of CHWs into the formal healthcare system*
- *balance the scale-up of the program with the quality of care*
- *develop an increased awareness of the accompaniment model*
- *promote a deeper investment of CHWs in the community*
- *increase community involvement in community health*
- *harmonize monitoring and evaluation systems and tools*

The program integration is referred to as the Rwandan Community Health Program (CHP). This program is geographically based, with a male and female CHW responsible for 40–50 households. Each region’s two CHWs provide a critical link between the community and the health center. They conduct monthly home visits, offer education in health prevention and promotion, implement active case finding, and follow groups with specific needs, including children under five years of age, pregnant women, and women using family planning. In addition, they offer directly observed therapy and accompaniment to those with TB and/or HIV infection.

1.1 Linking clinicians to CHWs

You may experience resistance from healthcare professionals to your attempts to integrate CHWs into clinical care protocols. The reasons for this resistance vary. Physicians and/or nurses may not believe that persons without professional training in health care can be trusted with the responsibilities they are assigned, such as direct observation of HIV or TB medications, appropriate referral to a health center or hospital, or to provide accurate

health education. Others feel that including CHWs in the provision of care lowers the status of healthcare professionals. Compensation can also be a cause for tension, since it is common for health professionals in low-resource settings—particularly due to budget constraints in the public sector—to be woefully underpaid. There may be resentment that CHWs receive any pay at all when they have been viewed as volunteers in many settings. These tensions and the resulting resistance can present significant challenges when initiating and maintaining a CHW program.

The teaching and practice of social and community medicine is critical in building a team of health professionals who understand the importance of home visits, community participation, and the active, team-based engagement of CHWs—key components of a strategy to address the social determinants of health. Another way that PIH has sought to overcome such challenges is to facilitate meetings between CHWs and clinicians. For example, collaborative work with the MOH's staff to discuss the complementary roles of CHWs and other

clinical team members may foster acceptance of the crucial role CHWs can play in clinical care. In some instances, physicians consult with patients in the presence of the patient's CHW. For example, at the PIH-supported sites in Rwanda, a CHW is on duty during clinic hours to accompany any patient who might need or request this service. Following an initial meeting, holding monthly team meetings with all employees will encourage ongoing communication about programmatic and clinical issues. Trainings with physicians and nurses should also include sections on the importance of collaboration with CHWs. Consider having clinicians meet CHWs during CHW trainings, give them a tour of the hospital, and introduce them to other clinical staff.



Figure 2: A nurse in Rwinkwavu, Rwanda speaks to patients and to their CHWs about HIV treatment regimens



PIH NOTE

Both clinicians and CHWs in Haiti report a relationship of mutual respect and trust as a result of healthcare institutions encouraging collaboration and communities typically choosing CHWs over a number of years. To transform this mutual respect into shared case management, Zanmi Lasante, PIH's sister organization in Haiti, has implemented a referral sheet system, in which a CHW gives a referral sheet to the community member he or she is visiting, which the community member submits to the health provider at a health facility. At the end of each clinic visit, the clinician completes a counter-referral sheet for the community member, which includes instructions for the CHW for continuing home-based care. This system encourages communication between clinical staff and CHWs and also helps assure consistency and proper follow-up care. Communication between CHWs and clinical staff is further supported through monthly meetings.

1.2 Budgeting for a CHW program

Developing a CHW program requires substantial human, community, and financial resources. Marshalling all of these resources may take considerable time and careful planning. Your work plan should include budget considerations to ensure that adequate resources are available for your program. Consider the geographic area to be covered, the specific role(s) and tasks of the CHWs, recruitment costs, resources for supervision, CHW compensation, and methods for monitoring and evaluating your program. (See *Unit 12: Using monitoring and evaluation for action* for more on measuring impact.) At PIH, the CHW program costs are broken down into several categories:

- CHW compensation
- Supervision (community- and clinic-based)
- Training (food, transport, materials)
- Supplies (backpacks, shoes, raincoats, forms)
- Communications (cell phone, phone cards)
- Transportation (patient, CHW, supervisor)

Of this list of budgeted components, compensation and supervision are discussed later in this unit, and training—one of the most important ingredients of a CHW program—is treated in more depth separately, in *Unit 6: Improving programs through training*. Unit 6 discusses considerations for providing training for CHWs under various—and often complex—circumstances. For example, it is vital to ensure that trainings are standardized across programs and project sites, but in a manner that also equips CHWs to address specific concerns that may be particular to the local context. If

you are working in several districts in one country and the health problems are consistent across districts, CHWs in each district should receive training sessions that contain the same information that clearly reflects what tasks they are expected to do as a result of the training. However, if the needs vary by district, then the specific training may need to be revised or augmented with additional information. In 2010, for example, in Burera, a district in Rwanda with a high prevalence of respiratory disease, providing training on that subject was a programmatic priority. But in the Eastern province, which does not have such high rates of respiratory disease, we trained on the topic of malnutrition. It is important to make such decisions in consultation with the MOH at the local and district levels and ensure that the content of the trainings is aligned with national protocols. A standardized curriculum offers both a systematic approach to training and also provides an opportunity for measuring results of a CHW program. Funders may want to see the overall effectiveness of a CHW program—or training session—and a standardized curriculum that includes pre-test and post-test assessments, as well as other indicators, will provide useful information



Figure 3: Community health workers prepare to hand out monthly food baskets to patients at Socios En Salud in Peru

Photo: Socios En Salud

to make this evaluation possible. Such assessment tools can also be an effective way to identify programmatic strengths and weaknesses, and also help to provide information for program improvement.

In planning your budgetary need for supplies and communication, consider how they will fit into your program. For example, in Haiti, raincoats and appropriate shoes are a necessity for CHWs during the rainy season. In this case you would need to consider: where to procure the raincoats; when you will disburse them; guidelines for replacing lost or damaged raincoats; what kinds of shoes the CHWs will need (Will they be walking over rocky terrain or will they be on horseback?); how they will carry supplies; and what kinds of forms they will need to document their work and follow up with patients. In considering communication needs, a budget for cell phones ensures that CHWs can contact patients (when feasible), CHW supervisors, and the clinic.

Transportation is also an important consideration for implementing your program. In fact, one of the greatest challenges CHWs can face is reaching patients and transporting them to clinics. In determining how many patients each CHW can see in a given week, think about how easily they will be able to reach their patients and the population density of the catchment area. If houses are located far apart from each other, or over difficult terrain such as narrow mountain passes, then it will make sense to assign fewer patients per CHW. (See *Section 3, Recruiting CHWs*, for more on assigning patients to CHWs.)

2. INCREASING ACCESS TO HEALTH CARE

A successful CHW program has significant advantages for strengthening a healthcare system. With appropriate resources, training, and supervisory support, a CHW program can improve and increase access to health care through:

- Greater attention to vulnerable populations
- Local empowerment and community participation in the health system
- Patient advocacy
- Delivery of high-quality, community-based care
- Improved adherence to treatment
- Prompt management and referral of patients
- Surveillance and active case finding
- Task-shifting from overburdened clinicians and healthcare facilities
- Strengthening the local economy through recruitment of traditionally underemployed or marginalized groups, such as women and people living with HIV



Figure 4: A community health promoter (right) at PACT in Boston greets a patient outside of her house

2.1 Bringing health care to the patient

Given the shortage of healthcare professionals in developing countries, CHWs play a vital role in identifying unmet healthcare needs in their communities, by providing both basic treatment and by referring community members who would otherwise be unable to access care. Their ability to reach vulnerable patients in their homes means that patient health need not depend entirely on their ability to make frequent clinic visits and travel long distances in search of medical attention. The CHW can provide basic clinical support and health education that may promote primary as well as secondary disease prevention.

CHWs are themselves from the communities they serve and, as such, are uniquely situated to build trusting relationships with patients. CHWs often share the same daily challenges as the patients they visit, and are often able to successfully present new ideas to community members, such as the importance of prenatal care, or accessing treatment for malaria or childhood malnutrition. These shared experiences can foster a trusting relationship more quickly and may facilitate successful referral for medical or socioeconomic services. In addition, CHWs can deliver medications to patients' homes, provide directly observed therapy, offer first-aid (such as preventing significant bleeding) prior to obtaining the necessary urgent professional care patients may need, and visit households to conduct active case finding. They can also provide training and support for health interventions that do not require a facility (such as training and supervision in the provision of oral rehydration therapy [ORT]). CHWs can significantly reduce barriers in access to care by facilitating transportation, arranging for childcare, and reducing patients' fear of discrimination at the clinic and in the community.



Figure 5: A village health worker in Lesotho travels long distances on foot to reach patients
Photo: Ilvy Njiokiktjien



Figure 6: A community health worker distributes medicines to patients in rural Haiti
Photo: Elizabeth Whelan



PIH NOTE

At PIH-supported sites in Lesotho, the CHW's primary role is to link the patients to the PIH health facility. Lesotho is a small country (population approximately 2 million) with a mountainous topography that creates significant challenges for people in remote villages to access care. Due to the difficult terrain, in fact, CHWs who accompany patients must be under 60 years of age (older CHWs in Lesotho focus on health education instead of accompaniment). The patients they accompany to the clinic are HIV-positive and need initial and follow-up HIV and/or TB treatment. CHWs also accompany them to unscheduled visits, in the case of an emergency or worsening health condition. CHW accompaniment in Lesotho is vital, since the patient may not have the strength to travel to the clinic alone and relatives may not have sufficient knowledge to transport the patient safely. Due to poverty, most households lack the resources to travel to accompany a family member to the clinic; for example, only 12 percent of households in the country have running water, 7 percent have electricity, and there is no electricity in the mountains surrounding the seven rural clinics supported by PIH. A new group of CHWs was recently trained to accompany pregnant women, and CHWs in Lesotho also provide a broader range of services, including active case finding for TB in the community, directly observed therapy for HIV/AIDS and TB patients, tracking patients with missed appointments, holding monthly health education gatherings in their villages, and providing home visits. Home visits allow CHWs to develop rapport with the patient and his or her family, a relationship that often develops into one of trust, which then serves as the basis of the CHW's solidarity with the patient through their shared experiences of illness and poverty. Pragmatic solidarity is expressed in the practical support of providing food packages for TB patients during treatment, HIV patients during their first year of antiretroviral therapy (ART), and for malnourished children and adults. Several clinics are also now partnering with the UN World Food Programme to expand distribution of food packages to pregnant women and children under five years of age.

CHWs improve access to care by linking affected communities and the clinics that serve them and by alerting medical staff to ill patients, to families with special needs, and to community concerns. CHWs often act as the “eyes and ears” of a health center. That is, by observing the patients in their home environments, they have insight into any treatment challenges they may be facing, and can give physicians access to what could be life-saving information.

2.2 Clinical benefits of a CHW program

In addition to improving access to primary care, CHWs can also be trained to identify problems and refer patients for timely treatment of specific diseases, such as HIV/AIDS and TB. Patient prognosis is likely to improve if a given case is identified early on rather than at a later stage of the disease; by their role in this work the CHW becomes a critical part of the medical team. When CHWs can identify community members in need of care, ART can be initiated earlier and clinical outcomes can improve.



PIH NOTE

PIH has been able to strengthen the primary healthcare system in Haiti's central plateau by utilizing HIV funding to institute a network of CHWs. These CHWs connect community members to many types of services, including HIV/AIDS and primary health care. PIH has utilized disease-specific resources to address the root causes of illness, including extreme poverty and lack of primary healthcare services. This strategy has improved not only adherence to HIV/AIDS treatment, but also the health of community members more generally. CHWs' outreach in the community significantly increased the utilization of primary health services and instilled strong community-clinic bonds. In 2009, over 500,000 patient visits were recorded in PIH-supported public clinics and the hospital in Cange, and patient encounters overall that year—including CHW home visits—totaled 1.7 million. These statistics reflect the broad range of outreach of the CHW program in Haiti.

Since CHWs provide services and support for HIV-positive individuals in their homes, they have the opportunity to identify other family members or partners who may be at risk of HIV infection. This has promoted earlier identification of patients with HIV before the disease has progressed to AIDS. In this way, CHWs can help people maintain health, have a more effective response to ART (when needed), and promote safe sexual practices in HIV-discordant couples.

CHWs also have the potential to make other life-saving interventions accessible. For example, CHWs improve maternal and child health by connecting community members to antenatal care, referring pregnant women to facility-based services for emergency obstetrical care, preventing neonatal infections, promoting breastfeeding, advocating for and referring to family planning services, and encouraging HIV testing and enrollment in programs to prevent mother-to-child transmission of HIV. These many connections are possible because the CHW relationship is based on the notion of accompaniment. The CHW is typically invested in the patient's overall well-being, and frequent visits afford the time and space to have ongoing, low-pressure conversations about important health topics.

An effective CHW program can improve coverage of many interventions known to reduce child mortality. These include, for example, management of diarrhea and acute respiratory infections, case management of pneumonia, home-based malaria treatment, management of neonatal sepsis, recognition and referral of cases of child malnutrition, and increasing uptake of vaccinations. Child survival is enhanced by the CHW's focus on preventive interventions in addition to the identification of specific diseases.



Figure 7: A community health worker in Haiti checks a child for malnutrition following Hurricane Tomas

2.3 Social benefits of a CHW program

The emotional and informal psychological support that a CHW provides is often as meaningful to community members as their clinic referrals. For example, during HIV outreach, CHWs work to diminish stigma and discrimination through community sensitization. This can be accomplished through providing community-based education or by working with HIV-positive patients, supporting their ability to assert themselves in the community and “living positively” with HIV. The psychosocial support of CHWs can also reduce the common feeling of isolation when a patient has a stigmatizing illness, and may support the patient in safely disclosing HIV status to family and friends. CHWs may also identify other needs within the patient’s family, such as the need for children’s school fees, inadequate housing, or problems linked with lack of access to potable water and sanitation. Referral can be made for these services within the health center (if these forms of assistance exist) or to other organizations that provide these services.

Because CHWs are from the communities in which they work, they can be powerful advocates for community members. They are expected not only to provide medical and psychosocial support, but also to participate in meetings and advocacy activities, build solidarity, and establish a link to healthcare facilities. Based on their relationships with the communities they serve, CHWs are regarded as a credible source of health information, offering health education at local churches, schools, and other community events and providing health promotion materials (for example, condoms). CHW patient advocacy can also 1) link patients to health facilities for timely and appropriate care, 2) give attention to other populations who are vulnerable or have not accessed essential care (for example, those who are orphans, mentally ill, or infirm), and 3) promote community outreach and mobilization. (See *Unit 14: Maximizing impact through advocacy* for more on patient advocacy.)

CHWs can empower the community. For example, CHWs working with PIH’s sister organization in Mexico, El Equipo de Apoyo en Salud y Educación Comunitaria (EAPSEC, The Team for the Support of Community Health and Education), facilitate the process of “conscientization,” a translation of the Portuguese term “conscientização,” which is sometimes translated as “consciousness raising” or “critical consciousness.” An approach to



Figure 8: A community health worker (right) provides emotional support to a patient in Rwanda



Figure 9: A community health worker (left) and physician visit a patient’s home in the mountainous Chiapas region of Mexico

community empowerment developed by Paulo Freire, conscientization uses dialogue with community rather than didactic education to promote local solutions to address problems.⁴ Since 1989, PIH has collaborated with EAPSEC to improve medical infrastructure in the region and to recruit and train hundreds of CHWs called *promotores*. Over the past two decades, EAPSEC has partnered with dozens of indigenous and rural communities throughout Chiapas to develop local health capacity.

PIH's sister organization in Guatemala, Equipo Técnico de Educación en Salud Comunitaria (ETESC, Technical Team for Education in Community Health), also uses this approach to support the forensic and legal investigations that are part of the 1996 Guatemala Peace Accords. The government of Guatemala guarantees many rights to those affected by the brutal civil war, including financial restitution, health services, and exhumation and dignified burial of loved ones' remains. While laudable on paper, realizing these rights is all too often beyond the reach of victims because of language, education, and economic barriers. ETESC provides the crucial "legal accompaniment" that empowers victims to enact their rights. Staff helps individuals and entire communities to understand the legal process, complete bureaucratic requirements and, where necessary, hold government officials accountable for unmet needs. Overall, ETESC serves as a bridge between communities and government officials so that rights truly create justice and reconciliation.

Similarly, from the inception of PIH's partner organization in Burundi, Village Health Works, the local community has played a leadership role in developing every aspect of the health center, from the planning to construction of the physical building. This level of participation led to the formation of a Women's Committee, which is now engaged in all major strategic decisions at Village Health Works. The organization initiated a community health forum to broaden community involvement, providing opportunities to enhance community participation.⁵

2.4 Economic benefits of a CHW program

A community health program that compensates its CHWs creates jobs in poor communities. However, since many governments do not feel that CHWs should be paid for their work, it is important to be prepared to discuss the benefits of fair compensation as you develop and maintain your CHW program. Compensation ensures that CHWs can dedicate a minimum number of hours per week to these tasks; this is particularly difficult in resource-limited healthcare settings if programs must rely on a pool of volunteers. Compensation can also serve



Figure 10: A community health worker in Haiti gives an infant an inoculation
Photo: Matthew Lester

⁴ Freire, P. (2000). *Pedagogy of the Oppressed*. New York: Continuum.

⁵ For more on Village Health Works in Burundi, see Village Health Works. (2011). *Reflections on day one of the First Annual Community Health Forum: Kigutu, Burundi*. Retrieved online at: <http://villagehealthworks.org/kigutu-forum-day-1>.

as a source of motivation and may improve job performance. (See *Section 4* in this unit for more on compensating CHWs).

If appropriately trained and supervised, CHWs can decrease the cost of health care through shifting activities to CHWs (for example, treatment of childhood diarrhea) that are typically performed by less available and more costly healthcare professionals. Such task shifting can release clinicians' time for more complex tasks or to improve the quality of care. An effective CHW program has the potential to contribute to the overall economic health of a community through improving disease prevention and early diagnosis. With a reduced burden of illness, members of the community are able to work and contribute more productively.

3. RECRUITING CHWS

While the ratio of CHWs to community members will vary across countries and projects, it is important to ensure that no CHWs are overburdened such that they cannot fulfill their responsibilities. Understanding the physical topography as well as the scope of CHW interventions will help you decide on an appropriate ratio. Some factors to consider include: the distance CHWs must travel from one household to another; available transportation; safety of patients' neighborhoods after dark; and CHWs' other responsibilities and/or necessary income-generating activities.



Figure 11: A community health worker in Rwanda checks in on a former TB patient, to whom she delivered medication every day for a year

**PIH NOTE**

Examples from Lesotho and Rwanda demonstrate how different CHW caseloads may depend on community needs. Each CHW at most PIH-supported sites performs DOT for four to six community members, visiting each patient twice a day to observe them taking their medications. In Lesotho, however, the MDR TB treatment specialists serve only one or two community members at any given time. This is primarily due to the difficulty of travel and the complexity of the accompaniment and the time required to ensure that community members receive appropriate treatment in this context. To provide high quality care and support to patients, CHWs must be thoroughly trained in the multiple medications necessary to treat MDR TB as well as associated side effects. In addition, CHWs always accompany MDR TB patients during each clinic appointment. In Lesotho, where CHWs usually work in isolated areas, clear job descriptions and a code of conduct have improved the effectiveness of the CHW program. The environment is very different for CHWs in the PIH-MOH harmonized system in Rwanda, where a CHW is responsible for primary health care, general household monitoring, and general health education. Here, each CHW is responsible for between 40 and 50 households at one time. Their responsibilities are broader than those of a CHW trained to work only in HIV or TB, but they visit each household only once a month, rather than the daily visits that are part of accompaniment in directly observed treatment of HIV or TB.

Requirements and standards can change to accommodate different situations. For example, in Malawi, the MOH initially prescribed that each CHW would be limited to serving six patients at any given time. However, due to the high prevalence of HIV, it became clear that the number of extant CHWs could not meet this demand, and the maximum was raised to eight patients, as long as at least two patients resided in the same household.



TIP: *When collaborating with the MOH, find out whether there are minimum or maximum requirements for patient-to-CHW ratios before determining the ratio that will apply in your own program.*

CHW programs create jobs in communities that often lack viable sources of employment. It is important to hire from within the community as long as adequate resources for training and supervision are available; careful consideration of the local or overall community context is vital. Hiring individuals who live with the same conditions that the CHW program targets (for example, TB and/or HIV) also provides employment to those who may be marginalized while harnessing their personal knowledge for the well-being of others. If this strategy is realistic for your program, it is important to ensure that CHWs with pre-existing conditions are able to complete their work without contracting or spreading illness. Finally, before you begin to recruit CHWs, identify the accepted local procedures for recruiting CHWs or other health workers. Work with local leaders, such as village headmen, in order to ensure that your program respects community and MOH recruitment norms.

**PIH NOTE**

In Rwanda, CHWs are chosen by the community as a whole. The village headman, who has significant influence, calls a meeting, at which he, along with representatives from the MOH and PIH, explains the role and duties of a CHW, as well as the criteria for becoming a CHW. (See below for some common criteria.) Individuals then volunteer for the position, and a vote is held immediately, on the spot. Those present are asked to stand when the name of their preferred candidate is called, and the two (one man and one woman) with the largest number of votes are selected for the positions. The MOH representatives then send word to the health center, and the elected CHWs are entered into a database of new CHWs. Before they begin work, they must visit the health center, where they are given a literacy test. This will ensure that they will be able to appropriately fulfill their responsibilities, such as accurately completing household data collection forms. A new election is held if the new CHW is unable to pass the test. Since this is not uncommon, some districts actually elect three or four CHWs at a time to make the process more efficient.

Lesotho has two distinct recruitment processes, one for each type of CHWs—those who support the primary healthcare system in rural communities and those who support the MDR TB program. For the rural primary health initiative, a patient generally chooses a CHW from those already trained and living near his or her village. If no one is available and/or acceptable to the patient, PIH hires and trains someone who is recommended by the patient or the community at large. These people are often chosen and/or approved (formally and informally) by village chiefs in the context of a public gathering. The MDR TB treatment supporters are more highly skilled and undergo a more rigorous selection process. In this case, the MOH establishes teams of supervisors (who have been trained by PIH) to assist the health center in each district in identifying and training suitable candidates. Each supervisory team includes a Medical Officer, ART Nurse, TB Officer, and TB Coordinator.

In Malawi, PIH recruits village health workers through village headmen and Health Surveillance Assistants, who are MOH employees. Village headmen hold significant decision-making power in their communities and are therefore important stakeholders in the CHW program. Before the selection process begins, PIH staff hold a meeting with the village headmen who live within the PIH catchment area and discuss the PIH model, the CHW program, and the process of selecting CHWs. Village headmen select two people from each village to work with the program, and the HSAs who live and work in the area review these selections. After receiving the list of CHWs, PIH staff review it with both the village headmen and the Health Surveillance Assistants. Once selections are confirmed, the headmen and PIH staff inform the candidates, who then begin the training program. CHWs then vote anonymously to elect a CHW chairperson, who acts as a spokesperson for the group. Spokespersons in Malawi have advocated for the CHWs on topics that range from receiving soda at training luncheons to lobbying for higher salaries.

3.1 Interviewing candidates and criteria for selecting CHWs

While local endorsement is vital, the clinical team should also interview candidates who wish to become CHWs to see if they meet the eligibility requirements and qualifications, described below. Team members who may be involved in the interview process include doctors, nurses, social workers, or program managers. The candidates should also be asked to take a basic literacy test.

While the selection criteria may sometimes vary according to the MOH in different countries, PIH uses the following baseline requirements in selecting CHWs. A CHW should:

- Be an adult, usually over 18 years of age.
- Have basic literacy skills; they must be able to accurately read pill packets, complete simple forms, and take notes during regular training sessions.
- Be in reasonably good health; many CHWs have to walk long distances to and from patient houses and health centers.
- Live in or close to the community served; minimum residency requirements—usually around five years—are common.
- Have a background that is similar to that of the patients so that the patients feel comfortable sharing their concerns; this also enables the CHW to have firsthand knowledge of the problems and obstacles patients face every day.
- Be a trustworthy and respected member of the community with a strong desire to help the needy and a strong sense of empathy with those who are vulnerable and sick; a CHW's work focuses not only on improving health status, but also on social justice and solidarity within the community, by working to support affected individuals and households and by reducing social isolation.

4. COMPENSATING CHWS

Compensating CHWs has a number of important benefits for both the healthcare program and the communities it serves. First, payment for meaningful work provides a needed income for those in resource-limited settings. Second, compensating CHWs can strengthen their role as an essential member of the clinical team, thereby creating a stronger “bridge” between the community to the clinic or hospital-based setting. Third, payment—particularly when it is a fair wage and paid on time—can serve as a source of motivation for CHWs in performing their work reliably and effectively. Fourth, payment can also increase the amount of time CHWs are available on a weekly basis, can prevent turnover, and can promote program consistency. Finally, investments in CHWs can potentially increase uptake in medical services, promoting adherence to HIV and TB medication and resulting in long-term improved health outcomes in the community.

4.1 *Compensation structures at the site*

Compensation structures will vary by country and program. Find out whether there are labor regulations that affect compensation, in addition to any minimum or maximum wage requirements or other regulations, when budgeting for the CHW program. Some programs either choose to or are mandated to cap salaries at the same level as those paid to schoolteachers or other civil servants. In some contexts, CHWs are paid a baseline salary and are then given an incentive bonus for each sick community member they see. In other places, CHWs receive compensation through a cooperative, whose members pool their funds to support it and have equal control over its operation. Additionally, many systems

involve performance-based financing, in which CHWs receive compensation following the completion of certain responsibilities, such as monthly home visits or the accurate collection of household data. CHWs who have a higher skill level—such as those that work with patients with MDR TB—may receive a higher monthly salary compared with CHWs who are responsible for more general outreach. This is the case at the PIH-supported site in Lesotho. In Haiti, Women’s Health Workers (another category of trained health staff) are compensated more than the typical CHW due to the greater knowledge base necessary to carry out their work.

When planning a compensation structure, consider if and how CHWs will be paid, whether or not they will receive bonuses, top-ups, or other financial incentives. If CHWs receive payment, determine how much they will receive and the schedule of payment. Types of payment may include:

- Money for meals, transportation, income from the sales of products
- Monthly stipend
- Monthly salary
- Performance-based financing
- Cash for tasks (If so, how much will you offer for what tasks?)
- Access to membership in a cooperative

4.2 Payment method

There is no universally standardized amount or payment method for CHWs. At most PIH project sites, CHWs are paid in cash following monthly trainings or check-in meetings. This encourages attendance and emphasizes the importance of regular communication and ongoing education. In an effort to encourage saving, we help CHWs open bank accounts, and pay through direct deposit when possible. (See *Unit 8: Establishing a financial system* for more information.) Consider the source or sources of payment, which may include:

- MOH with government funds
- MOH with NGO funds
- NGO with government funds
- NGO with NGO funds



Figure 12: A community health worker in Rwanda proudly shows the new chairs he bought for his home in rural Rwanda

4.3 Non-financial incentives

In addition to payment, consider what non-financial incentives your program may be able to offer. Non-financial incentives generally include ongoing training (a “non-negotiable”), certification, advancement opportunities, formal recognition, uniforms, backpacks, bicycles, cell phones, labor, and food baskets.

5. SUPERVISING CHWS

Systematic supervision is a necessary part of a successful CHW program. It is imperative that CHWs have clear expectations, and are regularly supported and mentored as they fulfill the goals of the CHW program. Integral to structured supervision are clear job descriptions, consistent feedback meetings, and ongoing training and education. (See *Unit 6: Improving programs through training* for more on training CHW supervisors.) CHW supervisors (i.e., managers, clinical staff) must be included in national training plans. Supervisors should be able to perform all the tasks a CHW is expected to perform and be familiar with reporting and recording as a core component of their managerial skills. Supervisor training should also emphasize coordination between CHW programs, clinical programs, and health facilities through coordination meetings and integrated work plans. These strategies should be in place in advance of training.⁶ While its implementation will vary by country (and sometimes even by region or district within a country), supervision generally includes review of patient records, routine visits to patient homes, and regular meetings with supervisees to discuss concerns or share information.

Typically, CHWs are directly supervised by clinical staff, usually a doctor or nurse involved in the care of patients in the CHW’s target area. It is important to discuss supervisory responsibilities with MOH staff and other stakeholders to ensure that lines of reporting and distinct responsibilities are clear. As your program expands, CHWs who have gained knowledge and experience over time can supervise less-experienced members of the team. For example, clinical staff can choose candidates who have shown exemplary performance as CHWs, or who have demonstrated an ability to manage others. A supervisor may oversee up to 50 CHWs, so he or she should be comfortable with asserting authority and have good time-management skills. The length of time the CHW has been working and his or her level of education are also factors that can be considered when choosing supervisors.



Figure 13: Health promoters practice taking blood pressure at a workshop in southern Chiapas, Mexico

⁶ See Note #2.



PIH NOTE

In Rwanda, the integration of PIH and MOH CHW activities has resulted in a supervisory system that is linked with the MOH Health Center system (see Figure 14). The health center director (titulaire) supervises all medical and related services, including supervision of a community health nurse. The community health nurse works with other health center nurses to oversee the CHW supervisors at the cell (village) level, organize monthly meetings, and perform unannounced home visits. The CHW supervisors (who were previously CHWs themselves) oversee the work of approximately 20–25 CHWs. The CHW supervisors monitor the work of CHWs also through unannounced monthly home visits and monthly meetings with all CHWs. Supervisors monitor whether CHWs are appropriately assessing the health and well-being of community members, making referrals as needed, treating designated illnesses at home, maintaining accurate records, and responding to community members' needs appropriately and compassionately. A supervisory tool (such as a structured form) allows the CHW supervisor to assess that CHWs are providing high quality care at household visits, conducting all required activities at visits, keeping their records up-to-date, and responding to patient concerns appropriately. Another supervisory tool for the community health nurse allows him or her to collate information about patient identification and treatment and to address concerns during monthly meetings. Finally, the health center submits collated community health reports to the community health nurse at the district level, which helps to inform district-level interventions. Monthly reports are provided to the MOH that outline the number of children vaccinated, treatment provided by the CHWs and health center, and other outcomes related to maternal health, disease follow-up, deaths, and CHW supervision and monitoring. Supervisory tools are informed by a health registry maintained by CHWs. The registry provides an overview of populations served, including lists of pregnant women, potential TB patients, children with malnutrition, and household visits.

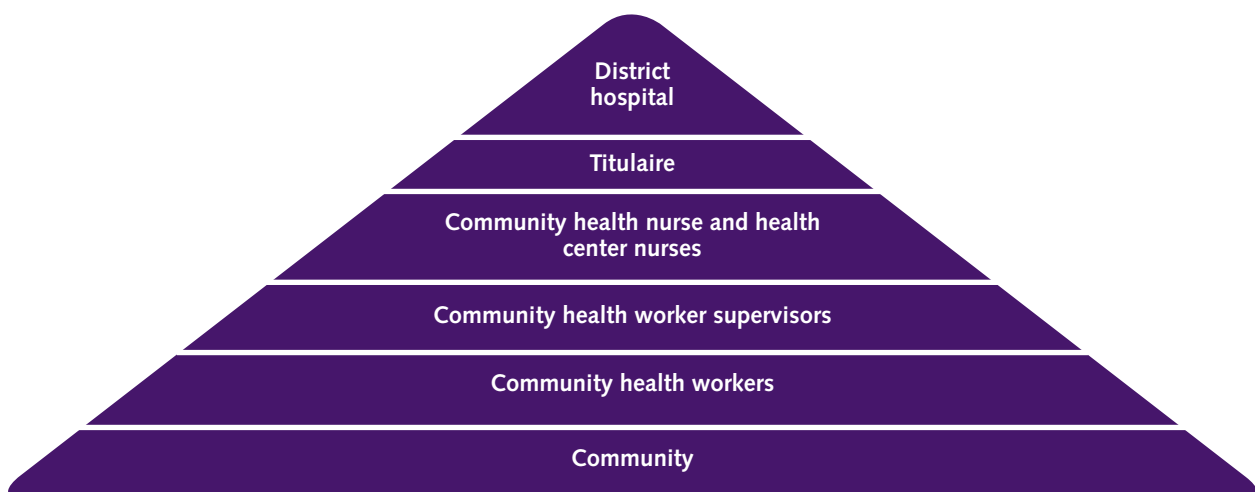


Figure 14: Organizational Structure for Community Health in Rwanda



PIH NOTE

CHW supervision in Lesotho illustrates the role of forms and reports in monitoring performance and results (see Figure 15). Each CHW supervisor oversees approximately 12 CHWs and is in turn supervised by the CHW coordinator. The CHW coordinator, who is based at a healthcare facility, reports to the site administrator and the nurse in charge, both of whom ultimately report to the clinical management team and the M and E coordinator. The M and E coordinator analyzes reports and provides feedback to CHWs and their supervisors, which is used to improve programs. CHWs complete a monthly report for their CHW supervisor. In turn, the CHW supervisor completes a report that summarizes the information received from each CHW and also tracks specific activities, such as weighing and vaccinating children, public gatherings related to health, and defaulter tracking, that is, keeping a record of patients who miss or “default” on their scheduled clinic appointments. The CHW coordinator summarizes all activities by CHW supervisors and CHWs and also provides defaulter details. This information is compiled from a “defaulter tracking” form that CHWs complete. Given the limited capacity for photocopying in Lesotho, CHWs maintain ledgers and create new tracking charts every month in a notebook. CHW supervisors transcribe information from the forms onto the ledger books and hand it on to the central M and E team for compilation in three-ring binders, entry into an electronic database, and analysis. All CHWs must fill out their ledger each month as part of their performance-based stipend.

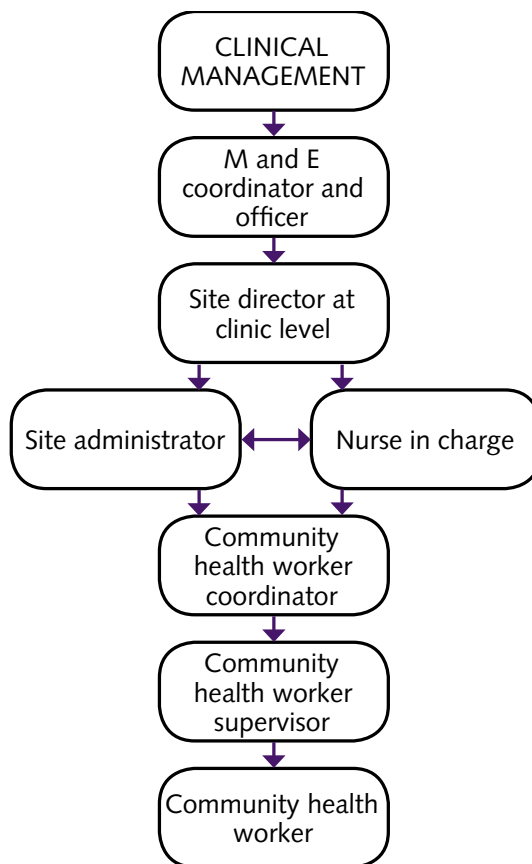


Figure 15: Organizational structure of CHW supervision in Lesotho

5.1 Roles and responsibilities of CHW supervisors

CHW supervisors monitor the work of CHWs, providing oversight and mentorship. Depending on the level and context of integration within an MOH supervisory structure, there may be supervision expectations and tools already in place to help your program plan such oversight and mentoring. It is important to meet with relevant individuals at the MOH to understand any applicable supervision structures, and to understand ways in which your system might correspond with these structures. Examples of some of the core competencies of CHW supervisors may include:

- Understanding the roles and responsibilities of community health workers
- Understanding the roles and responsibilities of CHW supervisors
- Understanding the role of CHW supervisors within the broader MOH structure and vision for community health
- Implementing supportive supervision
- Active listening, observation, and possessing good communication skills
- Giving constructive feedback to CHWs
- Carrying out supportive supervision during monthly home visits to CHWs and the households they serve
- Planning for and implementing monthly meetings for CHWs
- Addressing challenges that they and the CHWs they supervise face

Depending on the scope of your CHW program, supervision may include ensuring that CHWs visit community members regularly in order to monitor general health and well-being, referring appropriately, and administering medications correctly. The CHW supervisor will review the forms that CHWs complete to ensure that they are filled out correctly, and will conduct routine or surprise home visits in order to verify reported information and address any questions or concerns that may have arisen. Additionally, supervisors must identify topics for further training and communicate this to relevant individuals, helping to arrange, plan, and implement formal classroom training or informal mentoring as needed. Furthermore, supervisors must ensure that lines of communication remain open between the health center staff and CHWs, meeting regularly to address relevant concerns and collaboratively develop solutions. Finally, CHW supervisors are responsible for orienting new CHWs to their work. Supervisors are, in many ways, accompagnateurs to the CHWs, offering them guidance, support, and clear expectations, modeling the attitudes and support by which CHWs will accompany community members to improve their health and well-being.



Figure 16: The two oldest village health workers in Nohana, Lesotho

5.2 MOH and other levels of supervision

The example of Malawi illustrates how the MOH may intersect with health facility-based CHW training and supervision. In Malawi, both PIH and MOH employees are involved in managing and implementing the CHW program at various levels. The program presently includes not only CHWs but also CHW coordinators, Environmental Health Officers (EHO), and Health Site Administrators (HSA). The CHW coordinators are PIH employees who help manage and oversee the CHW program. They are the primary PIH contact for the cadre of CHWs, and for the staff who interact with the program. CHW coordinators:

- Recruit and hire CHWs
- Organize all CHW trainings, including location, food, transportation, and training staff
- Participate in and conduct trainings
- Manage the CHW payroll
- Maintain a database with all patients and their CHWs
- Link CHWs to HIV and TB patients
- Link CHW with other PIH staff
- Manage any issues with individual CHWs
- Provide support to CHWs
- Monitor and evaluate all CHW activities

While the CHW coordinators are PIH employees, both HSAs and EHOs in Malawi are MOH employees. EHOs function as the district level managers of the MOH's public health programs. They are in charge of the public health response to specific disease outbreaks and also supervise HSAs. All EHOs must have attended Malawi College of Health Sciences for either three or four years, depending on their degree. Their training includes epidemiology, emergency response to epidemics, food hygiene and safety, water and sanitation, and administration, but they do not have any clinical training. In PIH catchment areas, they conduct trainings with the support of PIH staff, strengthening PIH's relationship with the MOH and with the community.

The EHOs also facilitate monthly CHW trainings, while the HSAs supervise the CHWs hired by PIH. HSAs and EHOs live in or near the communities that they serve. In addition to outreach responsibilities in the communities in which they work, they play an integral part in the supervision system. Both HSAs and EHOs hold CHWs accountable for fulfilling their responsibilities by conducting home visits and reviewing the outcomes of their patient caseload. HSAs often attend CHW trainings in order to update and refresh their own knowledge. In addition, HSAs conduct assessments of children that CHWs identify who may need additional nutritional support. The HSA is then responsible for enrolling children in nutrition programs if necessary.

**PIH NOTE**

PIH clinicians in Malawi take an active role in supporting and mentoring CHWs and HSAs, ensuring (among other responsibilities) that all members of an HIV-positive adult's household are tested for HIV and treated, if necessary. At one monthly meeting with HSAs, a physician discovered that a large number of children with HIV-positive mothers had not been tested. In coordination with the HSA, he scheduled visits to three of these homes to investigate what barriers to HIV testing the families were encountering. The HSA contacted the CHW responsible for accompanying those families in order to schedule the visits. By the time the physician arrived a few days later, all of the children in question had been tested—and were negative. Without such active awareness and support from clinicians, these children might not have been tested for HIV.

CONCLUSION

A CHW program can, if implemented appropriately, significantly improve health outcomes, particularly for the poorest members of the community. The role of the CHWs and the goals of the program in which they work often vary widely. In PIH's accompaniment model of care, patients can build a trusting relationship with a CHW who will accompany them in solidarity through their journey back to health. In addition to direct accompaniment, CHW programs can provide a broad range of other primary as well as secondary prevention services. The CHW role can be expanded to fit the needs of the surrounding population, whether through training, CHW management of a specific disease, directly observed therapy, or by CHWs serving the wider needs of the community as generalists. Strategies that are available to help organizations work with CHWs typically serve to improve access as well as the quality of care that is provided in resource-limited areas. CHWs provide a critical link between health facilities and the patients they serve while enhancing the facility's ability to bring health care to the patients in the community.



Unit 7

Resources

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