

COMMUNITY HEALTH
WORKERS AND
COMMUNITY VOICES:

PROMOTING GOOD

HEALTH

A Community Voices Publication
National Center for Primary Care
Morehouse School of Medicine

OCTOBER 2003

BY

Marguerite J. Ro, DrPH
Henrie M. Treadwell, Ph.D.
Mary Northridge, M.S., Ph.D.

Community Voices
HEALTHCARE FOR THE UNDERSERVED

www.communityvoices.org

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AND COMMUNITY VOICES:
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The National Center for Primary Care at Morehouse School of Medicine is the program office for the Community Voices initiative. The initiative involves eight learning laboratories across the nation and is targeted at ensuring the survival of the safety-net providers and strengthening community support services. For more information on Community Voices publications, please visit www.communityvoices.org.

Opinions and conclusions expressed in this publication are those of the author(s) and do not necessarily represent those of the W.K. Kellogg Foundation.

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About the Authors/Editors

Marguerite Ro, MPH, DrPH, an assistant professor at Columbia University's Mailman School of Public Health and School of Dental and Oral Surgery, works primarily on improving access and utilization of health services by vulnerable populations. With the Community Voices initiative, she works with eight community collaborations on informing policy to improve access to oral health, mental health, and general health services. She also leads the national program management team that provides support for the American Legacy Foundation/Community Voices Tobacco Initiative. Addressing the social determinants of health, including social capital, class disparities, and racial/ethnic disparities are major components of her research and the policy technical assistance that she provides.

Henrie M. Treadwell, Ph.D., is a senior scientist at the National Center for Primary Care at Morehouse School of Medicine. Dr. Treadwell is a former program director at the W.K. Kellogg Foundation. She spearheads the national program office that supports the Community Voices initiative, funded by the W.K. Kellogg Foundation. Her major responsibilities include program design, oversight and administration of strategic initiatives to improve access to health coverage and services. Dr. Treadwell's distinguished career has included chairing the Division of Mathematics and Natural Sciences at Morris Brown College, a historically black college and university. She is recipient of numerous fellowships and awards and is a published author of numerous monographs and peer-reviewed articles.

Mary Northridge, M.S., Ph.D., is Editor-in-Chief of the American Journal of Public Health. Dr. Northridge is also an Associate Professor of Clinical Sociomedical Sciences at the Mailman School of Public Health of Columbia University, where she conducts community-based participatory research on environmental and social determinants of health, scholarly and practical applications of joint urban planning and public health frameworks, and advocacy and teaching around environmental and social justice issues. Dr. Northridge is forging a new model of public health research, scholarship, teaching, and service by combining her leadership at the American Journal of Public Health, community-based "urbanism and public health" initiatives in Harlem, New York City, and service at the national level through her work with the Community Voices initiative and the American Legacy Foundation/Community Voices Tobacco Initiative to enhance the infrastructure and dissemination of knowledge and results of community-based public health initiatives.

Contributors *(in alphabetical order)*

Sherry Adeyemi
Baltimore City Health Department

Ricardo Dios Aleman
Proyecto 2000

Gina Arias
Alianza Dominicana, Inc.

Stephanie Chen
Columbia University

Sunanda Holmes
Harrison Institute

Jason Newman
Harrison Institute

Leda Perez
The Collins Center for Public Policy, Inc.

Jessica Perlmutter
United Way of Miami-Dade

Marta Pizzaro
Miami, Florida

Wayne Powell
University of New Mexico

Amber Rickert
Columbia University

Jacqueline Scott
Harrison Institute

Michael Tan
Harrison Institute

Elizabeth Whitley
Denver Health

Deborah Zahn
Community Voices Oakland

Preface

Reaching out into homes and into the community to promote healing and wellness as an integral part of practice is as old as health care. But this practice is threatened.

Prevention was a hallmark of health providers' work many years ago. And assessing the local context, as it contributed to health, was considered as *sine qua non* in prescribing intervention and treatment. Community health workers used to conduct outreach, back when physicians made house calls, and public health nurses delivered services and conducted routine surveillance and prevention activities. These activities were compromised when some felt that it would be more efficient to deliver care somewhere other than in homes and in communities. Some may have considered it too dangerous for frontline workers to go into neighborhoods, or that greater quality could be assured if everyone came to a central facility. Or perhaps it is simply that the profession became "professionalized" and it was no longer "modern" to go out to where the people lived.

The reasons for withdrawal from the community are unclear. What is clear is that the health care system, if measured by the ultimate benchmark of equity, or no disparities, is an extremely poor performer particularly when one considers the fiscally intense resourcing of facilities and of the current first tier providers. Far too many of America's poor and underserved cannot access the clinic or provider office to obtain the basic health and associated services that they need to remain well. For many, the barrier to care is often the difficulty in finding someone who will take the time to talk and direct them to the various services and resources they need. No one has ever proven that going and reaching out was or is an ineffective or non-cost-accountable way of maintaining the health of people and of communities as a whole.

Reversing the tide to bring back what was valuable — what worked in past models of service and outreach — is challenging. We seem to have become a nation that requires unparalleled sophistry about cost-effectiveness of health outreach workers yet, other health costs rise exponentially. At the same time, we know intuitively and factually that our health systems save money when people access care for prevention versus costly care as a result of preventable emergencies or chronic conditions. (see "CHWs Improve Quality and Reduce Costs" in this document). A more user friendly conduit that gets people into care is needed.

The story of a community health worker (a.k.a., promotora, doula, lay health advisor, outreach worker, frontline worker, etc...) of reaching and improving the health of individuals seems simplistic, yet is not simply related. The story is one of special people willing to see and able to understand how health is diminished or improved by social place, educational achievements, economic opportunities, quality of housing, among other factors. Community health workers are able to weave together an agenda to help change individual circumstance while insuring access to appropriate health care services. Too many individuals don't receive assistance and are unable to find their way to appropriate and effective health care as the walls around the systems appear to be too high for many to scale.

One wonders what we were thinking when services were withdrawn from the field and placed within walls. Evidence continues to mount showing that some groups within this country consistently experience disparate access and treatment, and unequal outcomes. Many health systems and agencies are working to remove the barriers of the intellectual, cultural, and physical walls by putting into place individuals who can bridge the gap between institutions and those individuals or communities who need care. Bridging the gap is only the most basic element of what community health workers provide when assisting the poor, underserved, and disconnected in search of healing.

The art of communicating, of reaching, of touching individuals effectively in order to heal is perhaps the most promising hope that we have of eliminating health disparities while we mend a broken health care system headed toward financial meltdown. Yet, using the cadre of community health workers that we *know* works so effectively in bringing people into care and in reducing costs seems not to have gained priority national attention. This document seeks to tell the comprehensive story of the community health worker, the work of outreach, preparation for this work, and options for financing. We also hope that this document will move many to action: to the use of community health workers, and to the work of educating policy makers about the integral role that these frontline workers can and must play in making our health system whole and fiscally stable.

Henrie M. Treadwell, Ph.D.
Senior Social Scientist,
National Center for Primary Care
Morehouse School of Medicine,
and Director, Community Voices

Introduction



Tens of millions of Americans will go without health care this year, even though they may be suffering from painful and debilitating illnesses. Many will delay seeking medical care until their conditions are extreme — even life-threatening — simply because they cannot afford to see a doctor or lack a trusted source of health care. Meanwhile, the number of underserved individuals and families continues to balloon: 43 million Americans are currently uninsured, and steadily growing numbers are underinsured. Additional barriers within the health care system — such as institutional biases based on race/ethnicity, gender, age, and social class — may make accessing adequate health care even more difficult. Common obstacles include having no means of transportation and no child-care assistance. Often, a failure to receive correct and accessible medical information translates into poor health choices. The absence of available, affordable, and appropriate health care continues to be one of America's greatest challenges.

Community health workers are also known as:

lay health advisors
promotoras
community health advisors
community health representatives
outreach workers
patient navigators
doulas
frontline workers

They can help improve the quality of care while reducing costs.

Consequently, legislators, policymakers, providers, and consumers are searching for feasible strategies to overcome the barriers to providing increasingly inaccessible and costly health care that have contributed to troubling health disparities among groups. While there is no quick fix to the overall problem, one promising strategy that has been used internationally and which many communities have begun to adopt is the enlistment of community health workers (CHWs).

Community health workers (CHWs) are community members who work almost exclusively in community settings and serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care.¹ CHWs are employed in diverse health care settings, including community-based organizations, insurance companies, hospitals, and health departments. Importantly, they come from the same underserved neighborhoods and share the same cultural experiences as the people they serve, thus bridging the gap between health care agencies and local communities.

Through their first-hand experience and understanding of underserved and marginalized communities, CHWs are able to tackle the socioeconomic and cultural differences that often result in disparities in health and health care. U.S.-based and international CHW programs have successfully demonstrated the effectiveness of CHWs in helping underserved individuals access health care in appropriate manners. CHWs reach underserved populations more effectively than high-cost media campaigns or high-tech interventions and can help improve the quality of care at comparatively low cost.

This report documents how CHWs address the problems of health disparities, poor access to care, and the rising cost of health care. Challenges that exist in expanding current CHW programs are also examined. Policy options around finance, workforce, and delivery of care will be discussed. Based upon reported local and international successes, widespread adoption of CHW programs may prove effective in improving the health and health care for all Americans.

The Growing Field of CHWs



In the United States, CHWs are part of a growing field of social and human service assistants, that is, paraprofessionals who support health and social service providers by assisting individuals, families, and communities to access and receive health and social services. The Bureau of Labor Statistics recently projected that social and human service assistants will be among the fastest growing careers, with a 76 percent increase in positions expected between 2000 and 2010. In 2000 alone, social and human service assistants numbered approximately 129,000 individuals, and held about 271,000 part- and full-time positions.² The lack of a standard definition makes it difficult to determine the total number of “official” CHWs working in the United States today. No recent count of CHWs has been conducted.

A CHW may have many different titles, but without a doubt s/he has a reputation in her/his community for being respectful, trustworthy, good at listening, responsive to the needs of others, and in control of her/his own life circumstances.⁴ As members of the same communities they serve, CHWs are well-versed in the ethnic, cultural, social, environmental, and historical experiences that shape the behaviors and knowledge of their communities. Due to this valued perspective, CHWs may be more effective in promoting preventive behaviors and disseminating health information than health care providers who, more often than not, do not share the same background with those they serve.

CHWs Reduce Disparities in Health

For many underserved communities, disparities are not limited to the arenas of health and health care, but are part of everyday life. Discriminatory treatment due to race, age, class, and gender prevents members of marginalized communities from gaining equitable access to employment, housing, and education. People of color are disproportionately represented in lower socioeconomic strata, lower quality schools, and lower paying jobs. They also face substantial barriers in accessing and receiving quality health care. As carefully documented in a recent Institute of Medicine report, bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health.⁵

As a result of frequent encounters with unequal treatment, mistrust often exists between underserved community members and health care providers, community-based organizations, government entities (including state and local health departments), and health care institutions (both academic and non-academic). In African American communities this mistrust of health care providers stems partly from historical precedent. Consequently, African Americans often question the origin and spread of diseases such as HIV/AIDS, and avoid participation in clinical trials and interaction with subsidized health care. Unique but no less inexcusable discriminatory experiences have fostered similar



apprehension among other racial/ethnic groups. Distrust becomes more difficult to overcome when providers do not resemble their clients in terms of race/ethnicity or life circumstances.

CHWs can play a major role in overcoming this mistrust. For health care systems and providers, developing and working with CHW programs is key to building relationships with marginalized communities and easing their wariness. As previously mentioned, CHWs are members of the communities they serve who are distinguished because of their roles as trusted sources of information. They operate in formal and informal networks, and have the ability to discuss health issues with clients that some may consider sensitive.

CHWs also play an important role in breaking down the cultural divides that often exist between providers and communities of color. The lack of cultural understanding may result in providers' incomprehension of clients' health issues, and patients' incomprehension of providers' instructions. CHWs act as both linguistic and cultural interpreters, educating providers about health beliefs and practices particular to communities, such as the use of traditional medicines and home remedies. By educating providers about the cultural norms of communities, providers can better relate to their clients and deliver more appropriate care. For community members, CHWs can translate the medical information given by providers into lay terms. This is especially important for individuals whose primary language is other than English.

CHWs disseminate other vital health information to communities, such as advice on finding health care providers, standards for preventive care, and information regarding health crises, e.g., outbreaks and epidemics. They also follow up with patients concerning the correct use of medications and other aspects of chronic disease management, e.g., for diabetes, asthma, hypertension, and other primary care sensitive conditions, thereby reducing preventable health visits. As a result of the valuable translation services and cultural understanding that CHWs provide, patients and health care providers can have more productive relationships that lead to better health outcomes.

“The community health worker has played an important role in cultural competence and primary care efficacy at AHS.”

—Sherry Hirota,
Asian Health
Services

Roles and Functions of CHWs

CHWs Offer Health Advice

An important role of CHWs is to act as information brokers in communities. A large percentage of their time may be spent providing health information and guidance to clients. Critically, CHWs are able to listen to and understand the concerns of clients as a result of having some similar attributes as the people they serve, as well as deliver accurate information to communities in culturally appropriate ways.

Community Voices-El Paso, a nonprofit community-based organization in El Paso, Texas, uses promotoras through its Community Access Program, Línea de Salud. Through a telephone hotline they operate in both Spanish and English, promotoras provide health information to the public, including referrals to social services and assistance with health insurance enrollment. Over a ten-month period (May 2001 through February 2002), 5,449 calls were received. Of these, 70 percent were for health advice; the remaining 30 percent were for social services. Over 93 percent of the social service calls were requests for assistance with health insurance. Besides providing health advice, promotoras provide referrals and follow-up with social service agencies — which is especially critical to the health of immigrant callers — including assistance with rent, citizenship, transportation, and finances.



CHWs Assist in Obtaining Health Insurance and Accessing Care

Access to health care remains a major problem for millions of Americans, due to lack of insurance and other geographic, cultural, and organizational barriers.⁶ Among those who struggle with accessing care are the uninsured and underinsured, people of color, rural communities, and other disenfranchised groups. Uninsured individuals often choose to delay or forgo preventive and primary health care services, which later results in emergency department visits and costly hospitalizations.⁶ Even among insured individuals, 38 percent report that they or their families experienced at least one problem accessing medical services in the past year.⁷

State agencies, health care providers, managed care organizations, and other health care entities are attempting to enroll those who are eligible for Medicaid, State Children's Health Insurance Plan (SCHIP), and other health insurance programs, but sizable numbers of people are still currently uninsured. The participation of promotoras and other CHWs in outreach and enrollment efforts has proven to be a far more effective strategy for reaching immigrant populations than traditional media-based campaigns.

Over the past 3 years, Alianza Dominicana, Inc., a community-based organization that serves northern Manhattan where a large percentage of residents are immigrants, has successfully implemented the promotora model to increase enrollment in Medicaid and SCHIP. The involved promotoras come from the immigrant communities of northern Manhattan and encourage insurance enrollment among their neighbors and at schools, day care centers, and other popular locations in their own neighborhoods.

“In addition to helping individuals and families access health insurance programs, [CHWs] provide resource referrals for food, clothing, employment, etc. They are health promoters, educators and health screeners.”

– Liz Whitley,
Denver Health

At Alianza Dominicana, Inc., formal training is provided to promotoras on outreach strategies and health insurance enrollment requirements and procedures. During 2001 alone, 3,940 individuals were enrolled in Medicaid and 1,700 in Child Health Plus (New York's SCHIP program).⁸ Similarly, since 1998, promotoras at Community Voices-El Paso have enrolled over 7,000 individuals in Medicaid, SCHIP, and the Community Voices Primary Health Plan.* Once individuals are enrolled in an insurance program, promotoras assist individuals in staying enrolled by easing the renewal process.

CHWs also have considerable potential to assist in the oral health care arena. Clients often complain that the chief difficulty in accessing dental care is locating a provider, particularly one that accepts Medicaid. Appointments are frequently missed because of lack of access to transportation and childcare services. Through established referral systems, CHWs direct consumers to oral health services, assist them with making and keeping their appointments, and advise them on using oral health services appropriately. Furthermore, CHWs may educate clients about providers' expectations and the importance of screening for oral cancer, and educate providers who are less familiar with the communities they serve about ways to create welcoming environments and offer culturally sensitive services.

CHWs build vital relationships between providers, administrators, and community members. Improving access to care, especially when resources are tight, requires that efforts be efficient, coordinated, and — whenever possible — collaborative. In addition to linking individuals to health systems, CHWs also link health systems to community lifelines such as churches, local businesses, and health and social agencies.

* The Community Voices Primary Health Plan was developed by the El Paso Community Voices Collaborative to provide health insurance coverage to some of the county's 70,000 uninsured individuals who live above 100 percent of the federal poverty level and therefore are not eligible for government funded programs.⁹

As part of Denver Health's community outreach program, community health advisors (CHAs) are specifically charged with developing partnerships with these types of community stakeholders in underserved neighborhoods. Developing partnerships has enabled Denver Health to identify opportunities to address health and social issues in a more coordinated manner, and respond more quickly to concerns expressed by various community groups.

Partnerships also provide new venues for reaching underserved populations. For instance, conversations between Denver Health's CHAs and the American Heart Association's volunteers helped identify the growing problem of heart disease among women in shelters. The two groups decided to collaborate in providing essential services and enrolling women in publicly funded insurance programs so that they could visit primary care providers, some for the first time.

The CHAs also discovered that lack of transportation created a barrier to women obtaining care, and organized transport to and from doctors' offices. As a result of working with women in shelters, the Denver Health CHAs realized that young, non-custodial fathers needed the same type of services, and thus a similar program was organized for them. Without these important relationships initiated by CHAs, significant opportunities to provide preventive care and link individuals to health care venues would have been lost.

CHWs employed by Asian Health Services and La Clínica de la Raza, community health centers in Alameda County, CA, also play an integral role in educating community members about health care policy and collecting information to be used to inform policy and health system reform. Legal and undocumented immigrants often delay or avoid seeking health care and social services altogether because of fear of being designated as a *public charge*.** CHWs are working to ensure that community members are not afraid of getting needed services by acting as trusted messengers who clarify immigrants' rights to health care benefits. These include participation in programs such as MediCal and Healthy Families, and access to services provided by community health centers.

“CHWs represent the first line of contact in many cases, and provide a segue for getting clients through the door for medical care.”

– Sherry Adeyemi,
Baltimore Men's
Health Center

In response to community input relayed by their CHWs, Asian Health Service and La Clínica de la Raza have moved from out-stationing CHWs in the community to having them work in their clinics. In doing so, they are able to better integrate CHWs with other clinic staff, identify community members eligible for health care coverage, and link enrollment for health insurance with receipt of services. This placement also reflects the reality that foreign-born individuals are often accustomed to different mechanisms of health service delivery and payment for services. The CHWs' "front line" expertise often informs practice and policy efforts undertaken by their affiliated clinics, as reflected in strides towards cultural competency, e.g., the development and implementation of linguistic adequacy standards and the financing of translation services, and integration of complementary and alternative medicine with Western-based medicine.

**Public charge is the designation used by the Immigration and Naturalization Services (INS) for persons who cannot support themselves and are dependent upon public benefits.

Stories from the Field:

Name:

Gomez Family
(Wife and Husband)

Marital Status: Married

Insurance: None

Health Status: Husband severely ill and disabled. Receiving daily nutrition from Ensure™ through a feeding tube.

Mr. and Mrs. Gomez are both undocumented residents of El Paso County, making them ineligible for most publicly funded health benefit programs. The Gomez family lives in one of the many colonias found along the U.S.-Mexico border. They were formerly in need of assistance with virtually all of the basic necessities of life, including food, rent, transportation, and health care. In September 2001, La Linea de Salud referred the Gomez family to Community Voices-El Paso.

Once referred to Community Voices, Ms. Lupe Duarte, a promotora, made

a home visit to conduct a needs assessment for the family. Multiple needs were identified, including problems with transportation, a severely ill husband who required a special nutritional supplement, assistance with rent, and lack of basic facilities in the home, such as a working stove.

Even though Mr. and Mrs. Gomez were both undocumented residents of El Paso County, Ms. Duarte was able to refer the family to various agencies for assistance, including the Salvation Army for rent assistance, local health care agencies for donations of an

CHWs As Indigenous Health Researchers

As with other public health practitioners, CHWs may also be regarded as indigenous health researchers seeking ways to improve health service delivery and care coordination for their communities. The practical experiences of CHWs are essential contributions to the evidence base used to plan public health activities and arrive at “best practices.” Wisdom gained through the experiences of CHWs and other indigenous health researchers is more than “anecdotal.” It is essential “data” for the evaluation of interventions delivered in real time to real people, and vital if CHW efforts are to receive sustained funding and broader support.

In summary, CHWs have been instrumental in a wide range of activities and functions to improve access to care. CHWs both reach out to community members in their neighborhoods, as well as bring community members into clinics. They have increased enrollment in insurance programs, gathered data essential for changing policy, and initiated services for communities based upon diverse and changing needs. CHWs have a crucial role to play in linking health systems with communities.



Lupe Duarte, one of Community Voices' promotoras, presents Mrs. Gomez with donations collected on behalf of the family.

ongoing and adequate supply of Ensure™, and assistance with citizenship issues.

Ms. Duarte “went the extra mile” by beginning a donation project for the Gomez family. She made phone calls to home health agencies, churches, suppliers of the much needed nutritional supplement, as well as retail outlets such as Wal-Mart, Walgreen, Target, and Sam’s Club.

Through her efforts, the Gomez family received several cases of

Ensure™ and commitments for future supplies. In addition to small donations from individuals and churches, Wal-Mart selected Community Voices as the benefactor of their 2001 “Project Giving.” Annually one of the local Wal-Mart stores donates a percentage of net sales made on December 1st to a deserving cause. The Wal-Mart donation of over \$2,600 enabled Community Voices to provide this family with additional assistance during the holidays and through the early part of 2002.

Doulas:

CHWs Who Provide Childbirth Care and Post-Partum Support

“Doulas” provide emotional and physical care to women throughout the childbirth and post-partum periods that complement the clinical services delivered by physicians and nurses. “Doulas” are individuals who are not friends or loved ones, but rather professionally-trained CHWs who provide support and information to women during pregnancy, labor and delivery, and the post-partum period. While doulas do not perform clinical tasks,^{10,11} they do teach breathing and relaxation skills to pregnant women and provide advice on labor and delivery. In doing so, they assist families in understanding their birthing options and enhance communication between women and their providers.¹² During delivery, doulas provide dependable physical and emotional support. After birth, “post-partum doulas” teach infant care techniques and provide respite care to mothers as they adjust to having their new infants in their homes.

In 2002, Doulas of North America (DONA), an international organization, reported a membership of 4,550 — which is larger than earlier figures — suggesting that the field is continuing to expand. While only a few studies have been conducted to determine if doulas are effective in improving the health of mothers and their infants, the evidence to date is encouraging. The results of clinical research indicate that care provided by doulas reduces the length of labor, the use of pain medications, and the number of Caesarean deliveries.¹⁰⁻¹²

Studies also indicate that women who were cared for by doulas were more likely to be breast-feeding without problems at six weeks, have higher self-esteem, be less depressed, and develop stronger attachments to their babies.¹³ In addition, evidence suggests that introducing doulas onto maternity wards may reduce the costs of hospital maternity services.¹⁰

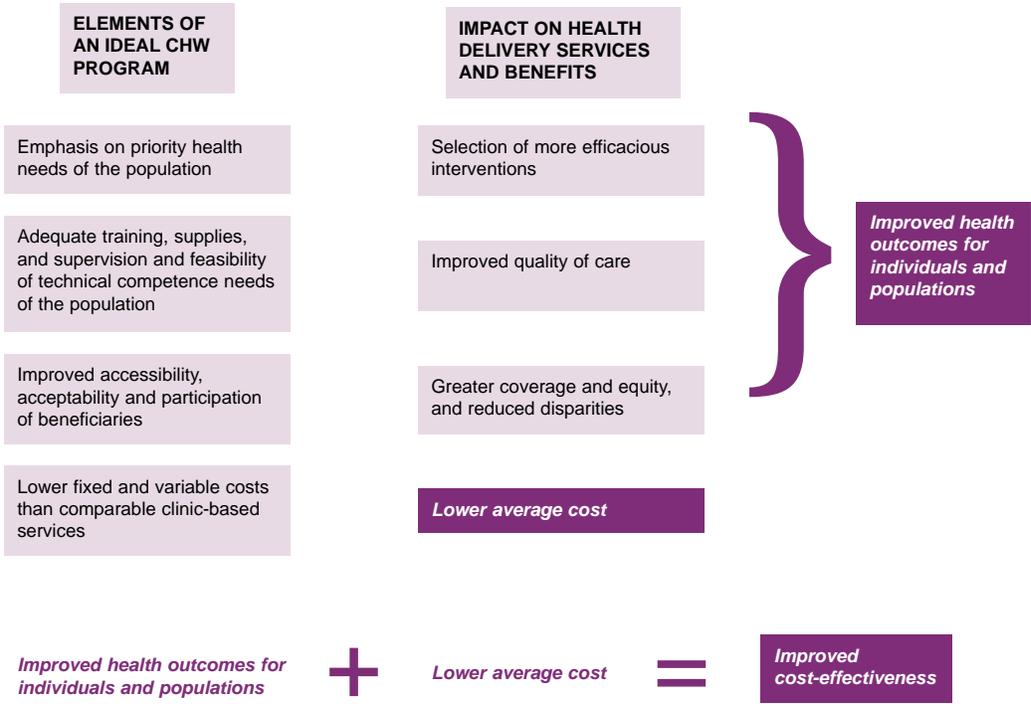
Doulas work in independent practices or may be associated with hospitals and/or agencies. Training and certification programs are being created across the United States. As with CHWs, doulas may be employees or volunteers. For women with limited financial resources, doulas may be available through community-based organizations and community health centers such as Support, Empowerment, Advocacy and Doula (SEAD). With support from Community Voices-New Mexico, SEAD enlists doulas to aid underserved Vietnamese and Latina women who speak little English. Doulas from SEAD follow women through early pregnancy up to six months after birth to help them navigate the health system and access care.

The foremost goal of doulas is to help ensure that women have safe and satisfying childbirth experiences. The physical, emotional, and informational support of women throughout this important life event is deemed essential for improving the health and well-being of mothers, infants, and their families.

CHWs Improve Quality and Reduce Costs

For health care systems, CHW programs are attractive because of the potential cost-savings from more appropriate use of health care resources and reductions in uncompensated care.

Fig 1. Model of CHW Cost-Effectiveness¹⁴



Few studies to date have been conducted on the cost-effectiveness of CHW programs. The data that do exist — both from the United States and elsewhere — suggest that the average costs of services provided by CHWs are significantly lower than costs at even the next highest level in the delivery system.¹⁴ Thus, there are potential cost-savings based on utilization and health outcomes from using CHWs to deliver services.

Each individual served by the CHWs cost an average of \$2,700 less over one year compared to an individual with similar demographics who was not served by CHWs.

In the BRAC tuberculosis control program, more patients in the CHW program were cured and fewer died.

An evaluation of the Community Health Worker Initiative (CHWI) cast favorable light on the costs and benefits of using CHWs. Researchers compared health service utilization rates of clients served by CHWs to a comparison group of clients with similar socio-demographics who were not served by CHWs. Maryland Medicaid Claims data files were examined for emergency department use, hospitalizations, and Medicaid costs. It was found that each client served by a CHW cost an average of \$2,700 less per year than a client in the comparison group. Assuming that each CHW carries an annual caseload of 30 clients, the researchers projected a savings of approximately \$50,000 per year for each CHW employed on the cost of program administration.³ The Kentucky Homeplace Project (KHP), another CHW program, is working to improve access to and utilization of appropriate services, and decrease the consumption of inappropriate and costly services. A program evaluation found that KHP saved Kentucky's health care system \$935,000 over one year, largely because the CHWs were successful in keeping clients out of nursing homes and hospital emergency departments.³

Beyond these relatively recent domestic achievements, international CHW-based health programs have proven successful over the long haul in reducing disease rates while saving money. The Bangladesh Rural Advancement Committee (BRAC) uses CHWs in its tuberculosis (TB) control program. At the two BRAC health care centers, a physician or manager oversees the CHWs, who provide the majority of health services. When compared to a government TB program in Bangladesh that does not engage CHWs, the total annual costs for the BRAC program were almost US \$4,000 less. In addition, more patients in the CHW program recovered from TB and fewer died.¹⁵

As these examples demonstrate, it is possible to create CHW programs that not only reduce costs, but also save lives. More detailed cost studies of CHW programs such as those reported here are needed to document what those engaged in the field already believe: CHW programs have the ability to improve population health while also reducing the drain on taxpayer money and insuring survival of current financially-strapped safety-net providers.

What's Effective: Learning From Abroad

The BRAC project is one of many models throughout the world where CHWs serve as essential links between communities and their health systems. In Peru, a small, impoverished community and its health system have designed a highly structured CHW program that has dramatically decreased preventable mortality and increased overall health (see the UNI Trujillo Promotora Model below). In Ethiopia, CHWs in poverty-stricken villages have dramatically reduced child fatalities from malaria. Close examination of these programs helps in understanding the full range of services that CHWs may potentially perform, as well as the challenges and achievements of implementing various CHW program models in different regions of the world. Such evidence may also inform CHW efforts within the United States and help tailor them to meet the health care service needs of diverse populations.



UNI Trujillo Promotora Model

Funded by the W.K. Kellogg Foundation since 1992, the UNI Trujillo Project aims to:

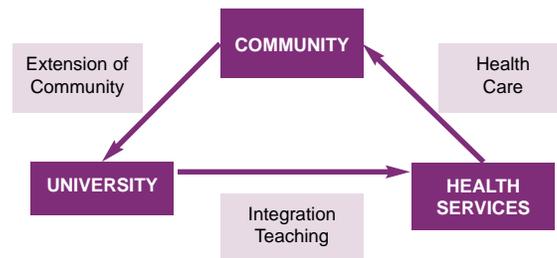
- Improve the delivery and quality of local health services;
- Increase the participation of community leaders and community members in health efforts; and
- Build and support the health care workforce.

Located in the Moche District of Trujillo, Peru, this project is led by the National University of Trujillo in partnership with community leaders and health workers.

A major outcome of the UNI Trujillo Project was the development and implementation of the Integral Familiar Health Care Model. This model takes a novel approach to health care by attending to entire families in accounting for their health needs. Based upon the belief that health care is a human right, this model encourages families to actively participate as citizens in addressing issues of health and health care.

Fig 2. Components of the UNI Trujillo Promotora Model

A “protected family” is one that has received the complete package of health care measures that informs, prevents, promotes, and provides for the well-being of the entire family.



An underlying concept of the UNI Trujillo promotora model is the use of “family surveillance” performed by CHWs in partnership with a network of local health workers, nurses, and medical students. “Family surveillance” redefines traditional health care goals by applying the concept of “protection,” usually used to signify that a child has been fully vaccinated or “protected” towards achieving family health. As defined by UNI Trujillo, a “protected family” is one that has received a complete package of health care measures intended to inform, prevent, promote, and provide for the well-being of the entire family. In addition, a “protected family” is one that has the capacity to address common health problems by recognizing and tackling them on its own, and knows when it is necessary to reach out to health practitioners for assistance.

To determine what constitutes a complete package of health care measures, an assessment is conducted to identify the most common health needs and demands of the families who are served by a community-based health facility. Once the most common health needs are identified,* objectives are defined for each, such as participating in and achieving routine prenatal visits, full courses of vaccinations, and boiled drinking water. Community-based health teams that include CHWs then work with families to achieve “protection.”

To implement this approach, the UNI Trujillo Project developed a set of cards and registration resources to allow local health teams to monitor, evaluate, and assess the progress of each family. All of the clinical records of each inhabitant in the district are organized as “family files.” Every member of the family has one card that includes information about her/his individual protection status, and another card that includes information about her/his family’s health status. Instead of being sorted alphabetically, the family files are organized by geographic zones, which are similar to census tracts. When a local health team visits a family, it uses the file to obtain a health history. This helps to both abbreviate response times to health problems and better monitor the family’s well-being.

Each zone of families is assigned to a health team responsible for performing a periodic survey to help spot potential problems or risks. Once a health issue arises, the CHW or “family watchman” (sic) — usually a woman — takes action to tackle it by providing primary health care measures and/or by reporting it to the health center. All measures undertaken — which may include education, counseling, advice in improving basic services, and nutritional guidance — are then recorded on the family card.

Every member of the family has one card that includes information about his or her individual protection status and another card that includes their family’s health status.

*The main conditions, problems, and risks that are identified and monitored include: presence of an infant, pregnancy, women of reproductive age having more than three children, a family member with an infectious disease or chronic illness, social problems, illiteracy, and the presence of more than five dependents. The surveillance conducted also includes tracking community sociodemographics. While some of these factors are not necessarily health outcomes, they may nonetheless affect family health.

Similarly, when a professional at a health facility identifies a problem or risk in a client, s/he reports it to the CHW, so that the CHW is able to monitor the client's progress when s/he visits her/his family. This two-way reporting is managed through a cardholder situated at health facilities. All cards are reviewed daily by the health worker who oversees the CHWs. Two card colors are used: yellow for following-up on the protected status of a family, and red for urgent situations. The latter are under the sole control of the health worker. Periodically, the health teams meet to evaluate advances in family protection, highlight any major problems, define new approaches or strategies, and train to improve primary health care competencies.

Selection to be a CHW is considered an honor.

The advances in protection goals are separated into three levels: (1) "attended," the lowest level, means that the family has only received isolated health care; (2) "controlled," the intermediate level, refers to when family members have received enough interventions for illness control; and (3) "protected," the highest level, signifies that family members have received all of the health care measures essential for virtual "protection" against the most prevalent local illnesses and health risks. The time required to gain protected status depends upon the situations of the family members: it may take up to nine months for a pregnant woman, one year for a child, and so on. If the entire family has lacked any previous health care, it usually takes about three years to have them all achieve "protection."

CHWs act purposefully in two directions: providing essential information to homes in the community, as well as alerting health centers about potential health crises. At the beginning of the UNI Trujillo Project, a larger proportion of involved families had "attended" status, and only a very small number had "protected" status. Five years after the implementation of the CHW program, a large proportion of involved families have "protected" status and only a very small number have "attended" status.



Maps and charts are used by CHWs to track the health status of families in each zone.

Training CHWs

The selection and training of CHWs was a critical part of the UNI Trujillo Project. Community leaders from each zone were invited to be considered as future CHWs. These initial meetings focused on the challenges, responsibilities, and necessary competencies of CHWs. Issues addressed included “how to knock on the door,” “how to treat families in trouble,” “how to gain a family’s trust,” and “how to approach social health problems.” A series of meetings were held to discuss the roles and responsibilities of CHWs, and to identify community leaders who had the most potential to become CHWs. Being selected as a future CHW was considered an honor. After selection, the CHWs met with a technical team and health workers to design the schedule for training.

CHW training emphasized both theory and practice. Theory included analysis of local and national health conditions so that CHWs could identify the most prevalent illnesses and health risks, understand why they occur, and then describe the primary care measures and referrals necessary for recovery. Practical training included learning to perform primary health care tasks such as giving a baby a bath, providing care to a newborn, treating fevers with physical measures, and preparing hydration salts. Health workers also instructed CHWs in administering education and counseling activities.

*Children who
have trained to
be CHWs in
Moche.*



The CHWs were further trained in the specific functions necessary for the UNI Trujillo Promotora Model's successful implementation, such as learning to use the reporting system, knowing the criteria for effective surveillance, understanding reference and contra reference procedures, describing and analyzing epidemiological profiles, obtaining customer satisfaction, and being aware of the national health care schedule. Training remains ongoing in order to address seasonal variations of particular illnesses and health problems, and also to focus on issues of particular concern identified by the Ministry of Health of Peru.

Results of the UNI Trujillo Promotora Model

To evaluate the program's results, the model examines both process measures and population health indicators. Remarkably, the local network of health services found a virtual absence of preventable maternal and child mortality in the last two years (just two cases of newborn deaths due to severe congenital malformations), while achieving significant relative decreases in infant pneumonia (from 4 percent of all respiratory diseases in 1995 to 0.3 percent in 2000) and diarrhea (from 15 percent of all diarrhea in 1995 to less than 3 percent in 2000).

An unexpected finding from the family surveillance is the apparent rise in chronic diseases over acute illnesses, a contingency not built into the original UNI Trujillo Promotora Model, which represents a new challenge to be addressed. Among the positive findings is that the UNI Trujillo program has improved health seeking for child and

maternal health care by over 50 percent, thereby demonstrating the ability of involved families to quickly identify the onset of health problems. In 2001, a dengue epidemic affected all of the districts in Trujillo, with the sole exception of Moche. Over the years, the Moche health facilities have received awards for quality service and development of innovations.

Increased community participation has been another positive outcome. Community leaders take an active part in district and provincial health programs, and often ask students for better methods and tools to improve their work. Several CHWs ran for government office in the last general and local elections in Peru — and won!

Replicating and Adapting the UNI Trujillo Promotora Model

The success of the UNI Trujillo Promotora Model has encouraged its replication and adaptation in other districts and provinces in Trujillo, throughout Peru more broadly, and even in Miami, Florida, USA. Community leaders and health professionals from the Ministry of Health, the Social Security Administration, and private institutions have taken the model — in whole or in part — and adapted it for their own communities. For example, a team from the Peruvian jungle used the protection concept to minister essential health care to rural children. Some health teams have achieved even better results than those reported by the original team in Moche.

What makes the UNI Trujillo Promotora Model so easily replicable and adaptable is its basis in the concept of “protection.” The package of health care services that constitutes “protected” status is arrived at in, with, and by consultation with each community. There is great flexibility in the model, allowing for its adaptation at any site. The package of health care measures differs according to the needs of each community and is appropriately tailored to meet those needs. Further, the chosen health care measures reflect the capacity and resources of both the health team and the community they serve. The collaborative process used to design the package of health care measures ultimately results in a commitment to achieving “protection” from both the health team and the community.

Remarkably, the local network of health services exhibits a virtual absence of preventable maternal and child mortality.

LEVELS OF PROTECTION

Attended: Family has only received isolated health care.

Controlled: Family members have received enough interventions for illness control.

Protected: Family members have received all the health care measures defined for virtual protection against the most prevalent local illnesses and risks.

Key elements of the UNI Trujillo Promotora Model that may be useful to consider in future efforts to replicate and apply it include the following “lessons learned.”

In relation to health providers and health agencies:

- Take into account the opinions and ideas of the involved CHWs for improving the program;
- Train CHWs to be on the look-out for health risks and problems, so that early identification and “prevention” can occur; and
- Talk from experience and embody your mission through your actions (instructors are better received when they espouse the principle, “do as I do, not as I say”).

In relation to communities:

- Work with community leaders, health providers, and health facilities from the beginning of the program, so that all involved parties have ownership of community health achievements;
- Harness the power of communal efforts;
- Be patient and listen carefully to identify problems and build solutions — community leaders often know the best way forward in arriving at solutions for their communities.
- Ensure continued community participation by including community leaders in the design of the project, shared responsibility for its successful completion, and public recognition of their essential contributions in improving community health and well-being.

The UNI Trujillo Promotora Model is one that may be applied, adapted, and refined to address a variety of health and social issues in any society. The concept of protection is flexible to suit each community’s needs, problems, capacities, and resources. A vital key to successful implementation of the UNI Trujillo Promotora Model is that communities must be engaged in their own efforts to improve their health. And surveillance must be valued and led by community leaders, not simply by researchers and health providers. The UNI Trujillo Promotora Model has been evaluated in four different communities within Moche — each with a different health profile and set of expectations — and all four have achieved positive results.

COMPONENTS OF THE UNI TRUJILLO PROMOTORA MODEL

Strategies and techniques for zoning the community population.

Card system that includes color-coded notes - yellow cards for follow-up visits to gain protected status, and red cards for urgent care.

Surveillance notebook, which registers any health event of families in the community.

Surveillance training plans and schedules for CHW, health workers, and students in medicine and nursing.

Evaluation meetings to monitor progress.

Community Voices-Miami: Adapting the UNI Trujillo Promotora Model

In the East Little Havana neighborhood of Miami Dade County, a community-based organization known as Abriendo Puertas, Inc. provides a safe, family-friendly place where immigrant families may go for health care and other services without fear of being reported to the authorities. East Little Havana is a unique and insulated neighborhood where inhabitants walk to work and neighbors all know one other. East Little Havana is one of the oldest areas of Miami-Dade County. Currently, it is a low-income, high-density community that faces social and economic challenges similar to those of other urban centers. The population of East Little Havana is 98 percent Hispanic, with a continuing influx of mostly undocumented immigrants from Central and South America.

Not surprisingly, many people in this neighborhood suffer from health problems associated with living in poverty, including diabetes, hypertension, and poor mental health. Their undocumented status and inability to speak English, however, has made many of them fearful of reaching out for help.



In order to achieve a more intensive, coordinated care approach to addressing the health needs of East Little Havana, Abriendo Puertas, Inc. applied the concepts of the UNI Trujillo Promotora Model to a program entitled, “Equipo del Barrio” (Neighborhood Team) — a partnership between CHWs known as “Madrinas and Padrinos” (natural helpers) and formal service providers. Madrinas and Padrinos are volunteers who want to give back to their community by linking those in need with available care and services.

Natural helpers, otherwise known as Madrinas and Padrinos, are volunteers who want to give back to the community by linking those in need with available care and services.

Abriendo Puertos, Inc., in partnership with the United Way, studied the UNI Trujillo Promotora Model and developed a coordinated care approach. Key aspects include:

- Create a health team that involves both clinicians and Madrinas and Padrinos;
- Identify patterns of access to and use of health services based upon specified risk factors of families within the targeted communities;
- Create “Family Charts” for at-risk families;
- Implement interventions that provide medical care, prevention measures, and/or education; and
- Evaluate process and health outcomes.

As Sheila J. Webb of the City of New Orleans Health Department observed, “communities are most knowledgeable about what their needs are and can provide the best viable solutions.”

The Madrinas and Padrinos play a major role in this initiative. They are responsible for outreach, case finding, completing the “Family Charts,” and linking families to all of the services they require, including medical services.¹⁴

As the program has evolved, lessons have been learned from the involved Madrinas and Padrinos, including:

- Madrinas and Padrinos and formal service providers need support in defining and understanding each other’s roles, and relating to one another and the individuals they serve;
- Madrinas and Padrinos need training and ongoing support in working with communities, particularly around issues of trust-building, confidentiality, and addressing difficult situations that may arise in the course of their activities, such as domestic violence; and
- It is vital to document and evaluate the participation of Madrinas and Padrinos in order to create a successful and sustainable program.

Community Voices-Miami found that adapting the Peruvian UNI Trujillo Promotora Model to East Little Havana was both feasible and effective.

Even in societies that have faced civil war, drought, and famine — such as Ethiopia, where the average life expectancy is only 47 years — there is considerable resiliency among desperately poor populations. CHW programs are ongoing in Ethiopia and other poor nations that reach out to people in their communities for solutions to their health needs, not the least of which is survival. In the United States, there are large immigrant populations from many of these same countries. According to Dr. Henrie Treadwell of the National Center for Primary Care at Morehouse School of Medicine and formerly of the W.K. Kellogg Foundation, “We have to talk about these issues and find ways of defining them. We have to understand the needs [of our immigrant populations] and how best to meet those needs.”

CHWs Reduce Malaria Death Rates in Northern Ethiopia¹⁶

A pioneering community health scheme in northern Ethiopia — in which mothers are recruited to teach other mothers how to treat malaria in the home — has led to a 40 percent reduction in overall death rates among children under five. Meanwhile, among the children who died, death rates from malaria are estimated to be a third of those in villages outside the scheme. Since 1992, village networks of community health volunteers — mainly subsistence farmers and, more recently, traditional birth attendants and mothers — have helped improve the diagnosis and home treatment of malaria in the Tigré region of northern Ethiopia.

Mothers are recruited to teach other mothers how to treat malaria in the home.

The aim is to ensure that malaria drugs are available to treat the disease before it becomes life-threatening, especially in very young children. Additionally, the community health volunteers provide health education at the village level, supervise the regular supply of preventive malaria drugs for pregnant women, and help organize vector control activities, including insecticide spraying and environmental management to prevent the build-up of mosquito breeding sites. After an initial seven-day malaria training course, each volunteer is expected to spend about two hours a day on malaria work. In practice, they often work many more hours.

The Community-Based Malaria Control Program was launched by the Tigré Regional Government in collaboration with WHO and with financial assistance from the Italian Cooperation. Ethiopia's long-running civil war had a severe impact on the region's health system infrastructure. When it ended in 1991, Tigré experienced large population movements — of returning refugees, demobilized soldiers, and economic migrants — and an outbreak of malaria in the south in which more than 500 people died. Almost 75 percent of Tigré is malarious and more than half the population is at risk. The volunteer scheme grew out of the region's well-established social system and strong commitment to community involvement. Wayne Powell of Community Voices-New Mexico observed, "their simple multidisciplinary and low-tech approach to major public health issues shows promise not because of its successes, but because in its resolve to stay based in the communities, it has avoided utter collapse of the nation."

Although established health services are still thin on the ground in this region (in 1998, less than half the population lived within 10 kilometers of a health center) almost half-a-million people are treated for malaria every year by a network of over 700 volunteers. The volunteers — all elected by their own communities — are trained to recognize the symptoms of malaria and dispense antimalarial drugs (until 1999 chloroquine, and since then, because of chloroquine resistance, sulfadoxine-pyrimethamine). Severe cases of malaria are referred for treatment within the health system.

Almost all CHWs (98 percent) were men. Women were initially considered unsuitable due to the low level of literacy (in 1994, only seven percent were literate), cultural expectations, and their heavy workload in the home. But in some districts, women are now increasingly becoming involved as volunteers. The aim is to help boost the disappointingly low number of women and young children who use the volunteer health workers' services for malaria treatment. An assessment of the program in 1994 found that two-thirds of individuals treated each month were over 15, and only 40 percent of patients were female. In response, some districts have recruited traditional birth attendants to do malaria work, and mothers are being recruited as volunteer coordinators to train other mothers. The dramatic fall in death rates, including malaria mortalities, among the under-fives in villages has encouraged an expansion of the program with mother coordinators. Despite few resources, this Ethiopian health program has proved astonishingly effective in raising the level of health care and prevention within their communities.

The program has led to a 40 percent reduction in overall deaths rates among children under five.

What's Effective: U.S.-Based CHW Models

Training and Curriculum

Most CHWs receive their training on-the-job and much of their formal instruction is limited to specific issues such as diabetes and HIV/AIDS. As CHWs are being recognized more and more as paraprofessionals, however, entities such as the state of Texas are standardizing instruction and certification programs. Denver Health provides monthly in-service trainings for their CHWs on a variety of topics, including speaking Spanish, honing communication and presentation skills, and providing tobacco cessation counseling. In partnership with the Community College of Denver, Denver Health has also developed a certificate program for CHWs, and celebrated their first graduates. Standardizing training and certification has become an important step in integrating the CHW profession into the health career ladder in Denver.

Developing a CHW Certificate Program - Denver Health

Denver Health and Community Voices teamed up with the Community College of Denver and the Denver Mayor's Office to pilot a CHW training and certification program to further develop the role of CHWs and strengthen the CHW vocation, in light of the educational and employment challenges CHWs face. A certificate can be very important, especially in agencies where credentialing is a major consideration in the hiring process. For individuals, the CHW certificate program is an entry way to a health career and is a valuable opportunity for those interested in health and who are transitioning from welfare to work.

With input from the Annie E. Casey Foundation, San Francisco-based and Denver-based CHWs, and community organizations, Denver Health designed an Essential Skills certificate for CHWs who successfully complete a 17-credit, one-semester program. To enter the program, potential CHWs must have earned a high school diploma or GED.

The first 20 students were enrolled in February 2002. The courses specifically designed for CHWs are listed and briefly described below.

Fig 3. CHW Certificate in Essential Skills (as of October 2002) – Community College of Denver

VOCATIONAL CORE REQUIREMENTS	CREDIT HOURS
Intro to Community Health Work Introduces students to the basic concepts of community health work, to the roles of community health workers and to basic practical skills necessary to the occupation.	2
Community Health Issues Introduces students to the multiple health issues for community health workers. Develops core competencies to function as a community health worker.	3
Community Health Resources Introduces students to the skills and resources necessary for community health work with clients in the community.	3
WORKPLACE CORE REQUIREMENTS	CREDIT HOURS
Community Health Worker Field Experience Provides students with an opportunity to apply community health worker knowledge and practice community health worker skills in community settings.	2
Intro to PC Applications	3
Reading 100-level course or higher	3
Communication for the Workplace	3
or Psychology of Adjustment	2

*Developing an Outreach and Enrollment Program —
Alianza Dominicana*

To encourage CHWs to take a leading role in rallying their community around the issue of health insurance, Alianza Dominicana of Washington Heights, New York City created a training program based upon Paolo Freire’s model of community mobilization. Freire’s model emphasizes consciousness raising and empowerment by viewing individuals not as victims of their circumstances, but rather as agents of change who are capable of acting upon the inequalities they experience. In keeping with Freire’s model, Alianza Dominicana believes that by raising the community’s collective consciousness, community members may themselves expose the structural causes of health care inadequacies. When community members provide information to other community members, they escalate awareness of vital issues concerning their community.

The learning objectives of the training course concentrate on community outreach and mobilization. They are divided into the following categories*:

ROLE IN THE COMMUNITY	COMMUNITY MOBILIZATION
Define/describe the community.	Define community mobilization.
Describe their place in the community.	Describe the importance of community mobilization for health insurance outreach.
Acknowledge the importance of their role as an outreach and enrollment specialist in the community.	LEADERSHIP
INFORMATION/ KNOWLEDGE	Encourage other people to become involved in community mobilization.
Define health insurance.	Build trusting relationships with community members through outreach efforts.
Describe the importance of health insurance.	Collaborate with other organizations to build an enrollment network.
COMMUNICATION	
Approach people and engage in conversation about health insurance.	
Listen without judgment.	

**Northern Manhattan Community Voices Outreach and Enrollment Training Workbook, 2002.*

This work demonstrates the importance of alliances between health and non-health agencies in developing strategies that will improve health and increase employment.

CHWs Reaching the Underserved

Even in underserved communities, there are subgroups of people who — because of race/ethnicity, social circumstances, and discrimination — are especially overlooked, neglected, and marginalized. Often, obtaining health care means waiting until a pain or illness becomes dire and then visiting an emergency department as a last resort. For such stigmatized subgroups — including members of immigrant communities (such as Cambodians, Eritreans, Haitians, Vietnamese, Afro-Latinos, and the Garifuna), men of color, and ex-offenders, trust is essential in linking individuals with medical providers. CHWs may play a critical role in reaching these subpopulations and assisting them with health and health care issues.

“Social Health Model of Care” — Asian Health Services and La Clínica de la Raza

Asian Health Services and La Clínica de la Raza are two community health centers that provide services for immigrant communities in Alameda County, California. As part of Community Voices-Oakland, these community health centers offer services in various languages, translation services and culturally-appropriate materials including educational fliers and enrollment forms to uninsured residents and immigrants in Alameda County.

As part of its “Social Health Model of Care” and “No Wrong Door” policies for enrollment and access, Community Voices-Oakland employs teams of multi-lingual CHWs through Asian Health Services and La Clínica de la Raza to:

- Assist Asian, Pacific Islander, and Latino immigrants to enroll in either existing public coverage programs (Medi-Cal and Healthy Families) or their program (Alliance Family Care);
- Provide community members with health and health care-related information; and
- Gather data and testimonials to provide feedback for policy efforts.

The Asian and Latino communities served by these two community health centers are largely comprised of families with limited or no English proficiency. These community members were born in numerous different countries and speak many different languages and dialects.

Their Latino clientele are primarily of Mexican and Central American descent; their Asian clientele are primarily of Chinese, Vietnamese, and Korean descent, with smaller percentages of clientele of Cambodian, Laotian, and Mien descent. Accordingly, the CHWs at Asian Health Services and La Clínica de la Raza reflect the variety of ethnicities present in the Oakland Bay Area and can therefore serve those communities individually and as a diverse team that can share cross-cultural perspectives, practices and values as a part of the work and decision-making process.

Community Health Representative Program - Reaching Native Americans and Alaskan Natives

The Community Health Representative (CHR) program funded through the Indian Health Service is the only CHW program directly sponsored by the U.S. federal government. Altogether, there are 215 CHR programs that employ 1,600 CHRs. The guiding concept behind the CHR programs is that American Indian and Alaskan Native community members — trained in the basic skills of health care provision and disease control and prevention — may successfully create change in community acceptance and utilization of Western care resources. Because CHRs are themselves community members, they are well-positioned to provide the information, education, and services that may improve the health of their communities. Since the CHR program began in 1968, CHRs have successfully established outreach networks through which health promotion, disease prevention, and health care access are delivered to Native American tribes.

All CHRs receive three weeks of basic health and medical training. Refresher training courses are also available. The services that CHRs deliver differ according to the needs of the communities they serve, although the type of tasks they typically perform include:

- Educating people about health hazards such as substance use, tobacco use, obesity, and stress;
- Organizing courses on home safety, environmental hazards, and community health;
- Arranging health fairs and preventive screenings;
- Conducting home visits as follow-ups to physician care;
- Transporting individuals for medical and dental visits;
- Conducting outreach and enrollment activities to assist people with obtaining health insurance coverage; and
- Informing providers and health systems about how to improve the delivery of services and the dissemination of health information. ¹⁷

Stories from the Field:

Making the Connection with Garifunas

In New York, New Orleans, Chicago and Miami, the Garifuna (Black Karibs) have emigrated to the United States to establish new lives, search for better opportunities, and improve their living conditions. The Garifuna are indigenous people of African and Carib-Indian descent whose migration from Central America began in 1940. Their adopted homeland has presented numerous challenges. Most of the Garifuna come from small villages and must quickly adjust to urban life with its norms, practices, rules, and conditions. Language is also a major obstacle, as most Garifuna speak Spanish and the Garifuna language.

While they are considered to be part of the broad and diverse Latino community, their unique culture and history makes them a distinct subgroup. The Garifuna people maintain a strong bond with their motherland, not only in spirit, but also in the financial support that they provide to their families remaining in Central America.

The Garifuna communities in the United States are still in the early stages of community and economic development, with few culturally appropriate resources for health and social services and information. Due to the pressures of migration and survival, the Garifuna women and men are prone to depression, addiction, and other stress related conditions.

Families struggle to find a balance between the Garifuna and American traditions and culture. The Garifuna children are at high-risk for physical and emotional abuse, drug and alcohol abuse, and other health-related problems. HIV/AIDS continues to be a major concern in this population. CHWs who are well-versed in the Garifuna culture, language, and community dynamic may play an important role in reaching these underserved people.



A Garifuna girl celebrates her heritage and carries the Garifuna flag.

CHWs Reaching Men of Color – The Baltimore Men’s Health Center

“Community Health Workers may be our most important resource in reaching men and closing the racial divide in health care outcomes. As a physician, I realize how limited I am in reaching people where they live and work. Men of color in particular, who are especially vulnerable to preventable health problems, may never make their way to any sort of health care without the guiding hand of a CHW. CHWs are the real ‘hands and feet’ of health care. Our challenge is to make sure that the role of CHWs is acknowledged and validated by advocating for reimbursement to cover their important work.” – John Rich, MD, Medical Director of the Boston Public Health Commission

There is a long-standing health crisis among men of color. Consider this: black men have a lower life expectancy at birth than white men, and the lowest life expectancy of any racial group of either gender. Black and Latino men have higher overall death rates than white men and a higher prevalence of preventable diseases. Overall, men of color are less likely to have health insurance — and consequently less likely to access health care services — than white men. When they do access care, men of color are more likely to receive inadequate care compared to white men.

Ideally — throughout their lives — men of color should be able to help prevent and identify health problems, as well as access equitable preventive and primary health care in a timely fashion. Yet, the reality remains that most men of color do not or cannot access care until health problems have progressed to serious stages. Even if men of color realize that they need health services, they may have difficulty navigating the health care system, particularly if they are uninsured. Male CHWs may play a significant role in assisting men of color in triumphing over these obstacles.

Male CHWs can play a significant role in assisting men of color in accessing needed health care.

A successful example of how male CHWs make a difference is found at the Men's Health Center in Baltimore, Maryland. Currently, the Center employs CHWs to provide health information to their clientele of primarily uninsured African American men. Because these CHWs are themselves African American men, they have a more natural rapport with their clientele than the health providers who are outsiders to the community. In addition, the CHWs of the Men's Health Center connect with the African American male population of Baltimore by being out in the community everyday. According to Mr. Robert Cheeks, a CHW from the Men's Health Center, "You have to be real. You got to go out there and get your feet wet. You have to get in the community, go to the churches, go to the alcohol groups, NA (Narcotics Anonymous), go to the barbershops and talk about the Men's Health Center."

This strong belief in community participation and engagement fosters support of and participation in Baltimore City programs. CHWs provide health information to the population not only by giving out flyers and pamphlets regarding available community resources, but also by listening to their clients' problems and concerns. This happens in a variety of settings: out in the community, in the Men's Health Center, and in the middle of focus groups where the men come and talk. In commenting on the people in the groups that he leads, Mr. Cheeks explains, "They open up their hearts. They talk about a lot of personal things. We must be very careful about how we respond to them, because they tell us very personal things." For many of the underserved men in Baltimore, CHWs are their first contact with the health system.

Male CHWs also provide support in other facets of their clients' lives. Mr. Frederick Sorrell, another CHW at the Men's Health Center, helps his clients find jobs in the area. In the words of Mr. Sorrell, "You must try to find resources for them. You work with the job component, referring them to work if they're ready. Most resources aren't readily available to them, we help them with wraparound services." Mr. Sorrell emphasizes that these other forms of support establish trust and are crucial components in linking men with much needed health services.

Both men emphasize that without CHWs, the Baltimore Men's Health Center would not be as successful. Mr. Sorrell says simply, "It's not possible to have the Men's Health Center without the CHWs. It's difficult to explain, but I can't imagine what the center would be without the CHWs." He adds, "When you put together a program like this, it's very important to have the right leadership. Without the proper leadership, you don't have a program. We've got that here."¹⁹

Boston Public Health Commission — CHW Program

In August 2002, the W.K. Kellogg Foundation announced a national demonstration project on men's health to expand the important work established in Baltimore. As a result, grantees will have the opportunity to use male CHWs to reach men of color. In one program, the Boston Public Health Commission is training young men of color to be CHWs. They are recruited into a nine-month training program where they receive training, CHW certification, life skills, social justice training, and men's reproductive health instruction. Upon graduation, they are then placed in community-based organizations. In addition, two case management teams will be established: one to link men leaving incarceration to health care services in the community, and the other to connect victims of violence to health and social care services. Each team will consist of a case manager and a CHW.

The above examples illustrate the dynamic potential of CHWs to improve both the health and access to health care of traditionally overlooked populations. The fact that CHWs have been successful in both the urban populations of Oakland and Baltimore as well as the rural populations of northern California is a testament to their effectiveness as public health workers across settings. As highlighted previously, the resources required to train CHWs is minor compared to the benefits that are reaped by their presence in the community.

CHWs have been successful in both the urban populations of Oakland and Baltimore as well as the rural populations of Northern California, a testament to their effectiveness as public health workers.

Men are recruited into a nine-month training program where they receive training, CHW certification, life skills and social justice training, and men's reproductive health instruction.

*Best Beginnings
Ensuring a safe and healthy childhood –
Alianza Dominicana, Inc.*

Giving children and families a healthy start is the goal of Best Beginnings, a home-based primary prevention program designed to prevent child abuse and neglect and promote child health and development. Alianza Dominicana, Inc. of Washington Heights, New York City operates Best Beginnings in collaboration with Columbia University and the New York Society for the Prevention of Cruelty to Children.

Through the collaborative efforts of outreach workers, family assessment workers, and home visitors, Best Beginnings targets children below the age of five who live in Washington Heights, one of the most impoverished and underserved neighborhoods in New York City. Washington Heights is home to large numbers of immigrant families from the Dominican Republic. Indeed, more than a third of people living in Washington Heights are non-citizens of the United States. The social and health care statistics are sobering: almost 46 percent of the children in the neighborhood live in poverty, a large percentage of residents rely on public assistance, and almost 40 percent of the population are insured through Medicaid. Despite the neighborhood's economic challenges, there is a strong sense of community pride stemming from shared history, culture, and experience.

The Best Beginnings outreach workers and family assessment workers recruit families at 18 sites throughout the neighborhood of Washington Heights. Once a family is screened and found to qualify for program services, the family is connected with a home visitor who educates and assists the family for the duration of their time in the program. All outreach workers, family assessment workers, and home visitors are community members who speak the same language as the enrolled families and understand the challenges confronting them from their own personal experiences.

Best Beginnings home visitors undergo an extensive training course that covers the following topics:

- Screening and assessment of families;
- Provision of home visiting services;
- Utilization of health care;
- Use of informal support and community resources;
- Self-sufficiency;
- Child development and parent-child relations; and
- Child abuse and neglect.

As a result of this program, over 90 percent of enrolled families have been linked to health care providers and over 90 percent of the infants are up to date on their immunizations at 12 months. Families who participate in the Best Beginnings program have been linked to other health and social services, including job training and job placement programs.

Expanding CHW Programs: Challenges and Policy Options

Despite the growing development of CHW programs in the United States and abroad, major challenges threaten the sustainability of CHW programs. These obstacles include the lack of stable funding, the need for training and certification, and the need to institutionalize and integrate CHW programs into existing health systems.

Given the diverse services for individuals and communities that are provided by CHWs, a blending of funding streams is required to support CHW programs.

Financing CHW Programs and CHWs

Funding for CHW programs originates from a myriad of sources, including federal, state, and local agencies, as well as private sources such as foundations. Funding — be it public or private — is usually subject to funding cycles or time-limited periods, and is often directed toward specific health issues or population groups. Most agencies with CHW programs must try to manage with a patchwork of funding, resulting in heavy restrictions on their time frames, scopes of work, and program sizes. Continuous funding of CHW programs often depends upon the capacity of the host agency to constantly search for funds.

Part of the solution is to encourage states to support CHW programs by fully utilizing outreach and education dollars that are available through Medicaid and the State Children's Health Insurance Plan (SCHIP). Medicaid managed care organizations (MCOs) may be encouraged to support CHWs through their contracts (for example, by legally requiring MCOs to conduct community-based outreach and education). While both private and public funds are needed, increasing the availability of public funds would provide a more stable financial base for CHW programs particularly if the funds are viewed as a regular and continuing line-item expenditure, similar to the way that salaries for others on the health provider team are treated.

Medicaid as a Source of Funding

The Medicaid program is a potential funding source for CHW activities. Programs and clinics have made limited use of Medicaid reimbursement to fund outreach, health education, and Early and Periodic Screening, Diagnoses and Treatment (EPSDT) services. But Medicaid does not cover many of the services that CHWs provide. For example, CHWs often accompany patients to doctors' offices, not just to provide language interpretation, but also to make sure that culturally appropriate care is provided.

Through the Medicaid waiver system, CHWs may be able to tap into Medicaid funding streams, but this requires CHWs and their advocates to work closely with state Medicaid offices to craft appropriate waiver language. Services traditionally offered by CHWs or promotoras may be applicable under both waiver provisions (Section 1915 and Section 1115). With careful planning now, CHWs can be positioned to tap into the Medicaid system in a cost accountable and effective manner particularly as their work is seen as key in lessening long and short term costs for care.

Further development of the Medicaid billing codes for CHW activities will require that CHWs and their advocates understand the Medicaid system, and where the points of access may be. Understanding how Medicaid waivers and changes to Medicaid regulations may result in stable funding for CHW services is also important. Model language could be developed to present to state Medicaid agencies and the U.S. Department of Health and Human Services for inclusion in state waivers and regulations. Early preparation may allow CHWs and their advocates to move quickly when opportunities such as changing waivers or regulations arise.

FINANCE RECOMMENDATIONS

Maximize the use of Medicaid and SCHIP funds designated for outreach and enrollment to cover CHW services.

Examine the feasibility of Medicaid waivers so that CHW services may be reimbursed under state Medicaid programs.

Include language in MCO contracts that ensure the delivery of community-based outreach and health education services through the direct engagement of CHWs or by contracting with CHW programs.

Evaluate CHW programs to capture the costs and benefits of CHW work.

Building the CHW Workforce

WORKFORCE RECOMMENDATIONS

Standardize CHW training and certification based on core roles and competencies.

Ensure that hiring policies for CHWs are appropriate to the skills and knowledge that they bring and do not present unnecessary barriers (e.g., higher education degree).

For employed CHWs, assure living wages and fair benefits.

Examine opportunities to link CHW employment to job-training programs and establish CHWs as a step in a health/medical career ladder.

A number of challenges in employment and compensation impede the development of the CHW field. CHWs are often volunteers or part-time employees who are generally paid low salaries and often do not qualify for benefits because they do not work full-time. The National Community Health Advisor Study reported that over 50 percent of CHWs lack health benefits; an even larger percentage of CHWs lack retirement benefits. Half of the surveyed CHWs also reported having no basic sick leave or vacation benefits. Job security is another major concern due to the patchwork nature of funding for CHW programs.

As has been stated previously, CHWs face the same challenges in gaining employment, livable wages, benefits, and education as the communities they serve.

Positively, CHW programs are an entry way into the health care profession for individuals who may not have had true opportunities to consider a health care career. As CHWs gain experience, they often find new doorways open to them. Specifically, becoming a CHW helps expose people to the wide range of opportunities in public health, medicine, and the other health professions.

In becoming CHWs, individuals may realize for the first time that a career in public health and health care is a real possibility. Linda Okahara, the Community Services Director at Asian Health Services (AHS), reports that many of their CHWs pursue higher education to the benefit of themselves and the clinic. She believes that it is important to offer community members a broad range of career opportunities within the CHW field and public health. By retaining CHWs who pursue more advanced health careers, the clinic ensures that the voice of the community continues to be heard at all levels of the clinic infrastructure.

Integrating CHW Programs into the Health Care System

CHW programs are more common in some areas of health care, including preventing and treating HIV/AIDS and other STDs, managing chronic diseases such as asthma and diabetes, and improving maternal and child health, e.g., providing prenatal care and immunizations to reduce infant mortality than others. Overall, poor visibility and understanding of CHW programs has led to an underutilization of CHWs within the health care system. Health care providers, insurers, practitioners, and policymakers in designing effective systems must factor in community needs to better understand the integral function and value of CHWs in health care systems. In turn, CHWs in their training will understand more fully the health care system and the concerns and needs of providers, insurers, and policymakers and how CHWs themselves are integral and important to achieving good outcomes. With greater awareness and mutual understanding from all parties, CHWs will gain greater acceptance as vital and valued members of health care teams.

Providers assume that once people are introduced to a health system, they will utilize it appropriately and efficiently even though there is little to no education or support on how to use health care.

Examples of where CHWs can make a difference

HEALTH CARE SYSTEM RECOMMENDATIONS

Educate providers, health systems, policy-makers, and decision makers about the role of CHWs in health and human services.

Educate CHWs about health systems, the roles of the providers, administrators and policymakers, and how CHWs can interact with the various players.

Explore, validate, and demonstrate how CHWs can effectively reach underserved and hard-to-reach communities.

Build CHWs into health teams that address not only preventive and primary care, but also emergency health teams.

One opportunity to integrate CHWs into the health care system is to introduce services through school-based health centers. School-aged children often lack good primary care, and fail to see physicians at the recommended intervals to receive treatment for episodic and chronic health problems. To address these health concerns of school-aged children, there are currently over 1,300 schools that house health centers which provide a comprehensive range of services to children who otherwise would not have access to care. Managed care plans are working with these school-based centers because they see an opportunity to expand their capacities. CHWs may supplement the activities of physicians and nurse practitioners to better reach out to these children, and relieve the burden on parents while encouraging them to utilize needed health care services themselves.

Another opportunity to integrate CHWs into the health care system is to place CHWs in emergency departments. Since many uninsured and Medicaid-insured patients use emergency departments as their primary medical home, this venue is crucial for community interaction and education. CHWs could assist patients at emergency departments to:

- Understand the process of emergency department care;
- Enroll in available health insurance programs;
- Initiate a relationship with a primary care physician; and
- Access and utilize follow-up care and medications.

Further work is needed to highlight potential areas where CHWs would best benefit patients and most effectively apply scarce health care resources. Such research could then inform model programs that place CHWs in venues other than schools and emergency departments.

The Role of CHWs in Responding to Terrorism and Disasters²⁰

Recent hearings on Capitol Hill have revealed that our nation's public health infrastructure needs assistance in responding effectively to terrorism and disasters. Significant gaps in the system need to be filled to adequately protect the public's health. State and local agencies are scrambling to recruit and train personnel to be on-call when emergencies occur at night and on weekends. State health departments are working to bring together fragmented surveillance systems. County offices are struggling to develop adequate emergency communication systems. The response of Congress, the executive branch, and relevant federal agencies to Homeland Security policy and spending are in a state of rapid flux.

Missing from these activities is the need to inform and prepare communities which have traditionally been left out of the health care system altogether. Families living in impoverished urban and rural locales must deal with the constant problems of overcrowding, poor sanitation, and malnutrition, which provide fertile ground for infectious disease outbreaks. Poor and marginalized communities will become even more vulnerable during crises unless strategies are undertaken to ensure their safety. CHWs may provide a vital link between underserved communities and local, state, and federal governments and public health agencies in their efforts to counter terrorism and other health emergencies.

Both terrorist attacks and natural disasters require streamlined, well-planned, and timely response systems. The covert dissemination of biological agents presents a challenge in emergency response plans, as there is often a delay between exposure and onset of illness. It is imperative to quickly identify symptoms of illness from biological and chemical agents, whether inadvertently or intentionally introduced into food and water supplies. As CHWs work at the "front lines" in communities, they may assist residents in obtaining medical attention, and report any suspected outbreaks to public health authorities swiftly and fully.

CHWs are a vital link between vulnerable rural and urban communities and local, state, and federal governments.

The Centers for Disease Control and Prevention (CDC) is engaged in developing strategic response and preparedness activities for bioterrorism. Their focus is on five main areas:

- Preparedness and prevention;
- Detection and surveillance;
- Diagnosis and characterization of biological and chemical agents;
- Response; and
- Communication.

These areas overlap closely with what CHWs are already trained to do in their communities. Early detection, diagnosis, and prevention are regular duties of CHWs, and are also necessary in thwarting illness and injury caused by biological and chemical terrorism. CHWs are well positioned to notice suspicious symptoms, as they are often the first point of contact in health systems for isolated and vulnerable community members. CHWs may then direct clients to health providers for technical information and medical assistance. On the other hand, CHWs may receive information from public health officials for prompt dissemination to communities. By strengthening the health care infrastructures in outlying and poor communities, CHWs may significantly reduce medical response times in the event of an attack or natural disaster. Through their reassuring presence, CHWs may limit the ability of terrorists to incite panic and disrupt daily life, and help authorities maintain public safety.

Promoting Community Health Workers and Other Frontline Workers through Policy

Community health worker programs are struggling. At the state level, policy efforts have centered on defining the role of these frontline workers, training and certification, funding streams for frontline worker activities, and understanding the impact of frontline worker programs on health and community development. At the federal level, no policy measures have been enacted that specifically focused on CHWs, outreach workers, or related programs. However, there has been substantive dialogue around potential federal policies for patient navigators.

The policy recommendations in this section recognize the fact that despite differences in terminology and labels, CHWs, outreach workers, promotoras, patient navigators, community health representatives, and frontline workers play similar roles in health care delivery in the community. Overarching policies must consider these workers as “one” group to ensure sustainability.

On the vanguards of health care, these frontline workers have important perspectives and firsthand knowledge of the health care marketplace. As such, CHWs and outreach workers should work in collaboration with other health and social systems planners in developing public policy strategies to improve health care delivery.

Key actions to support and expand the use of frontline workers and frontline worker programs include:

1. Establish public funding streams that support frontline workers and frontline worker services (e.g. Medicaid reimbursement for an identified set of services provided by outreach workers).
2. Encourage states to support the use of frontline workers and frontline worker programs through their Medicaid managed care contracts. Build accountability measures where managed care organizations could demonstrate their community-based approach through the use of outreach workers and in the delivery of culturally appropriate services.

3. Include frontline workers as part of health care teams that coordinate care for special populations and vulnerable populations. This is particularly important in the current efforts to strengthen the public health infrastructure at the community and local levels.
4. Involve frontline workers in planning efforts to reform health systems particularly as it applies to creating a more accessible health framework for vulnerable populations.
5. Support, finance, and develop training and certification programs for frontline workers. Certification would reinforce CHWs, outreach, and other frontline workers as paraprofessionals and gain them additional recognition with providers and health systems.
6. Support research efforts that examine and evaluate frontline worker programs.
7. Support demonstration projects that examine the role and utilization of CHWs, outreach, and other frontline workers in improving access to care for vulnerable populations, particularly with models that involve coordinated care.

Conclusion

According to many experts — given the soaring costs of health care, the near record numbers of uninsured families, and the looming budget deficits — our health care system is headed for a “train wreck.” At best, the current safety net is badly frayed. Too often the communities most in need are the very communities who remain without access to care. We need to approach the issue of community health care with thoughtful reflection and creative foresight. CHWs are not a new idea. They may, however, be usefully revived as a key element in an overall strategy for addressing the complex health care crisis that this nation currently faces. By improving the quality of health care while also reducing the costs of delivering services to underserved communities, CHWs may be a vital cornerstone in any effort to rebuild our divided health care system that provides high technology medical care for the wealthy, and denies access to essential services for the poor.

As documented in this report, CHWs have the potential to intervene on behalf of the communities they serve in several essential ways. CHWs offer culturally appropriate, economically sound services that are directly relevant to the health care and social service needs of their community members. By placing their “ears to the ground,” CHWs are able to connect community members to appropriate health care providers, promote preventive health care measures, provide education about early signs and symptoms of disease, offer supportive shoulders to lean on, and thereby help to reduce health and social disparities among population groups. Serving as CHWs provides members of disenfranchised populations with opportunities to “give back” to their own communities, while educating and empowering themselves. Many CHWs are now being paid for their services, and more and more CHWs are earning benefits and receiving further training as a result of recent policy changes and legislative reforms.

CHWs provide a critical link between communities — particularly underserved communities — and the health care and social service systems that are intended to serve them. If the CHW movement is successful, it may be possible to use CHWs to help mobilize communities around other essential services, including educational reform, public transportation, and environmental protection. By valuing CHWs as passionate community advocates and leaders, we may begin to transform communities and create positive societal change through a groundswell of citizen action that embraces all of its members, regardless of the ability to pay for vital services. In this way, CHWs may be most effective in eliminating the egregious disparities in health that beset United States society, and make headway in addressing the vast inequalities in health among nations and population groups worldwide.

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Contacts

COMMUNITY VOICES CONTACTS:

BALTIMORE COMMUNITY VOICES
Baltimore City Health Department
210 Guilford Avenue, 3rd Floor
Baltimore, MD 21202
Phone: (410) 545-0823
Fax: (410) 396-1571

COMMUNITY VOICES MIAMI
The Collins Center for Public Policy, Inc.
150 E. Second Avenue
Suite 709
Miami, FL 33131
Phone: 305-377-4484
Fax: 305-377-4485

COMMUNITY VOICES NEW MEXICO
University of New Mexico School
of Medicine
MSC08 4600
1 University of New Mexico
Albuquerque, NM 87131-0001
Phone: 505-272-4590
Fax: 505-272-4780

COMMUNITY VOICES OAKLAND
1320 Harbor Bay Parkway, #250
Alameda, CA 94502
Phone: (510) 769-2241
Fax: (510) 769-2247
dzahn@chcn-eb.org

DENVER HEALTH COMMUNITY VOICES
Denver Health Community Voices
777 Bannock Street, MC7779
Denver, CO 80204
Phone: (303) 436-4071
Fax: (303) 436-4069

FIRSTHEALTH COMMUNITY VOICES
FirstHealth of the Carolinas, Inc.
Community Health Services
155 Memorial Drive P.O. Box 3000
Pinehurst, NC 28374
Phone: (910) 215-1922
Fax: (910) 215-5054

INGHAM COMMUNITY VOICES
Ingham County Health Department
P.O. Box 30161
5303 South Cedar Street
Lansing, MI 48909
Phone: (517) 887-4311
Fax: (517) 887-4310

**NORTHERN MANHATTAN
COMMUNITY VOICES**
100 Haven Avenue, Suite 27C
New York, NY 10032
Phone: (212) 304-7031
Fax: (212) 544-1905

AUTHORS:

Mary E. Northridge, Ph.D.
School of Public Health
Columbia University
60 Haven Avenue, 10D
New York, NY 10032
Phone: 212-543-9307
Fax: 212-342-2320
Email: men11@columbia.edu

Marguerite Ro, DrPh
Assistant Professor
Columbia University
154 Haven Avenue
1st Floor
New York, NY 10032
Phone: 212-304-7185
Fax: 212-304-5966
email: mr965@columbia.edu

Henrie Treadwell, Ph.D.
Senior Social Scientist
National Center for Primary Care
Morehouse School of Medicine
720 Westview Dr. SW
Atlanta, GA 30303-1495
Phone: 404-756-8914
Fax: 404-756-8911
email: htreadwell@msm.edu



**Community Voices is an initiative of:
National Center for Primary Care
Morehouse School of Medicine
720 Westview Drive, S.W.
Atlanta, GA 30310
Phone: 404-756-8914
Fax: 404-752-1198
www.communityvoices.org**

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